Jurisdictional Statement

81-2131

No.

Office-Supreme Court, U.S.
FILED
JUL 31 1981
ALEXANDER L. STEVAS,
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

JURISDICTIONAL STATEMENT

LAWRENCE G. WALLACE
Acting Solicitor General

STUART E. SCHIFFER
Acting Assistant Attorney General

GEORGE W. JONES
Assistant to the Solicitor General

WILLIAM KANTER
BRUCE G. FORREST
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 633-2217

QUESTION PRESENTED

Whether the income requirements prescribed in Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)), a provision which limits federal reimbursement of state Medicaid expenditures, violate the equal protection component of the Fifth Amendment when applied under the Massachusetts Medicaid Program.*

---

* George Hogan, Pearl Hogan, Celia Beberman, Henry Beberman, George Hunter, and Cecilia Hunter were named as plaintiffs in the complaint in the district court. The district court certified a plaintiff class (App. D, *infra*, 23a-24a) comprising "all (i) present and future Social Security recipients; (ii) who reside or will reside in Massachusetts; (iii) who are or will be disabled or 65 years old or older; (iv) who are or will be ineligible because of the amount of their incomes for Massachusetts Supplemental Security Income payments; and (v) who have or will have * * * medical expenses not subject to payment by a third party which exceed the difference between their countable incomes under the Massachusetts Medicaid regulations and the applicable Massachusetts Supplemental Income standard."

In addition to appellant Schweiker, the defendants in the district court were Charles Mahoney, Secretary of Human Services of the Commonwealth of Massachusetts, and John Pratt, Commissioner of the Department of Public Welfare of the Commonwealth of Massachusetts.

TABLE OF CONTENTS

	Page
Opinion below	1
Jurisdiction	1
Statutory provision involved	2
Statement	2
The question is substantial	10
Conclusion	27
Appendix A	1a
Appendix B	21a
Appendix C	22a
Appendix D	23a
Appendix E	25a
Appendix F	26a
Appendix G	28a
Appendix H	30a

TABLE OF AUTHORITIES

Cases:

Califano v. *Aznavorian*, 439 U.S. 170 24
Califano v. *Boles*, 443 U.S. 282 ..... 24, 26
Califano v. *Jobst*, 434 U.S. 47 ..... 24, 25
Califano v. *Torres*, 435 U.S. 1 24
Cleland v. *National College of Business*, 435 U.S. 213 ..... 24, 25
Dandridge v. *Williams*, 397 U.S. 471 ..... 14, 22, 24
Flemming v. *Nestor*, 363 U.S. 603 22
Freeman v. *Parham*, 475 F.2d 185 22
Fullington v. *Shea*, 404 U.S. 963, aff'g 320 F.Supp. 500 ..... 22, 25, 26, 27
Harris v. *McRae*, 448 U.S. 297 ..... 2, 25
Idaho Department of Employment v. *Smith*, 434 U.S. 100 ..... 24, 25

Cases—Continued Page

Jefferson v. *Hackney*, 406 U.S. 535 ..... 12, 14, 25
Maher v. *Roe*, 432 U.S. 464 24
Maine v. *Thiboutot*, 448 U.S. 1 ..... 21, 26
Mathews v. *De Castro*, 429 U.S. 181 24
McGowan v. *Maryland*, 366 U.S. 420 25
Rosado v. *Wyman*, 397 U.S. 397 ..... 12, 15
Schweiker v. *Gray Panthers*, No. 80-756 (June 25, 1981) 2, 3, 4
Schweiker v. *Wilson*, No. 79-1380 (Mar. 4, 1981) 4, 11, 21, 24, 25, 26
United States v. *Clark*, 445 U.S. 23 10
United States Railroad Retirement Board v. *Fritz*, No. 79-870 (Dec. 9, 1980) 11, 21, 22, 23
Vance v. *Bradley*, 440 U.S. 93 25
Weinberger v. *Salfi*, 422 U.S. 749 24

Constitution, statutes and regulations:

United States Constitution:

First Amendment 22
Fifth Amendment 6, 9
Fourteenth Amendment 6, 9

Act of July 9, 1973, Pub. L. No. 93-66, Section 212, 87 Stat. 155-158 5
Act of Dec. 31, 1973, Pub. L. No. 93-233, 87 Stat. 947:

Section 10, 87 Stat. 957-958, 42 U.S.C. 1382 note 5
Section 13(c), 87 Stat. 965, 42 U.S.C. 1396a note 3

Social Security Act, 42 U.S.C. 301 *et seq.*:

Title I, 42 U.S.C. (1970 ed.) 301 *et seq.* 4
Title II, 42 U.S.C. 401 *et seq.* 7
Title IV, 42 U.S.C. 601 *et seq.* 3, 4
Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.* 4
Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.*... 4
Title XVI, 42 U.S.C. 1381 *et seq.* 4

42 U.S.C. 1382(e)(2) 9
42 U.S.C. 1382e 4, 5

Constitution, statutes and regulations—Continued Page

Title XVIII, 42 U.S.C. 1395 *et seq.* 7
Title XIX, 42 U.S.C. 1396 *et seq.* 2

42 U.S.C. 1396a(a)(10) 2
42 U.S.C. 1396a(a)(10)(A) 3, 8, 12, 15
42 U.S.C. 1396a(a)(10)(C) 4, 5, 8
42 U.S.C. 1396a(a)(10)(C)(III) 5
42 U.S.C. 1396a(a)(17)(D) 4
42 U.S.C. 1396a(f) 3
42 U.S.C. 1396b(f) 2, 4, 5, 6, 8, 9, 10, 11, 21, 22, 25, 30a
42 US.C.. 1396b(f)(4)(C) 5, 32a
42 U.S.C. 1396d(j) 5

28 U.S.C. 1252 10
20 C.F.R. 416.230 9
42 C.F.R. Part 435, Subpart B 3
42 C.F.R. 435.603 9

Miscellaneous:

Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* (1968) 21, 26
113 Cong. Rec. (1967):

p. 3899 13
p. 22781 16
p. 22783 17
p. 22784 16
p. 22785 16
p. 23048 14
p. 23055 15
pp. 23061-23062 16
p. 23065 16
p. 23077 16
p. 23082 16
p. 23083 16
p. 23084 16
pp. 23084-23085 16
p. 23087 16
p. 23090 17

Miscellaneous—Continued Page

p. 23091 17
p. 23092 16
p. 23093 16
p. 23104 16
p. 23105 17
p. 23125 16
p. 23128 16
p. 23131 16
pp. 32845-32846 19
p. 33167 19
p. 33168 ..... 19, 20
p. 33169 20
p. 33170 18
p. 33171 ..... 19, 20
p. 33174 20
p. 36380 20
p. 36381 20
p. 36385 20
p. 36387 20
p. 36389 20
p. 36784 20
p. 36819 21

115 Cong. Rec. (1969):

p. 69 21
p. 85 21
p. 652 21
p. 5382 21

119 Cong. Rec. (1973):

p. 22606 5
p. 22645 5

45 Fed. Reg. 31782 (1980) 6
H.R. 5710, 90th Cong., 1st Sess. (1967) 13, 17
H.R. 12080, 90th Cong., 1st Sess. (1967) 14, 15, 17, 18
H.R. 618, 91st Cong., 1st Sess. (1969) 21
H.R. 1352, 91st Cong., 1st Sess. (1969) 21
H.R. 3272, 91st Cong., 1st Sess. (1969) 21

Miscellaneous—Continued Page

H.R. 8283, 91st Cong., 1st Sess. (1969) 21
H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. (1967) 20
H.R. Rep. No. 213, 89th Cong., 1st Sess. (1965).. 11-12
H.R. Rep. No. 2224, 89th Cong., 2d Sess. (1966).. 13
H.R. Rep. No. 544, 90th Cong., 1st Sess. (1967).. 15, 21
H.R. Rep. No. 92-231, 92d Cong., 1st Sess. (1971).. 4
President's Proposals for Revision in the Social Security System: Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess. (1967) 13, 14
S. Rep. No. 404, 89th Cong., 1st Sess. (1965)..... 12
S. Rep. No. 744, 90th Cong., 1st Sess. (1967) 19, 21
S. Rep. No. 92-1230, 92d Cong., 2d Sess. (1972) 4
S. Rep. No. 93-249, 93d Cong., 1st Sess. (1973)..... 5
Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. (1967) 14, 15, 17, 18

In the Supreme Court of the United States

OCTOBER TERM, 1980

No.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

JURISDICTIONAL STATEMENT

OPINION BELOW

The opinion of the district court (App. A, *infra*, 1a-20a) is reported at 501 F.Supp. 1129.

JURISDICTION

The opinion (App. A, *infra*, 1a-20a) and initial order (App. B, *infra*, 21a) of the district court were entered on November 21, 1980, and were clarified by an order (App. C, *infra*, 22a) dated December 22,

1980.[1] On April 9, 1981, the district court entered a final judgment pursuant to Fed. R. Civ. P. 54(b) (App. E, *infra*, 25a) modifying its previous orders and expressly invalidating the federal statute (42 U.S.C. 1396b(f)). Notice of appeal to this Court (App. G, *infra*, 28a-29a) was filed on April 22, 1981. On June 11, 1981, Justice Brennan extended the time for docketing the appeal to and including July 31, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1252. *United States* v. *Darusmont*, No. 80-243 (Jan. 12, 1981), slip op. 1; *United States* v. *Clark*, 445 U.S. 23, 25-26 n.2 (1980).

STATUTORY PROVISION INVOLVED

Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f), is reprinted at App. H, *infra*, 30a-32a.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Schweiker* v *Gray Panthers*, No. 80-756 (June 25, 1981), slip op. 1. Section 1902(a)(10) of the Act (42 U.S.C. 1396a(a)(10)) establishes the

---

[1] The government filed a notice of appeal (App. F, *infra*, 26a) following the entry of the district court's opinion and subsequent clarifying order, but did not docket the appeal in this Court due to uncertainty as to whether the district court had held the federal statute unconstitutional. See *United States* v. *Clark*, 445 U.S. 23, 25-26 n.2 (1980).

basic scope of the program. All participating states must provide Medicaid coverage to persons receiving benefits under one of the categorical assistance programs (*i.e.*, the "categorically needy"). 42 U.S.C. 1396a(a)(10)(A); see *Schweiker* v. *Gray Panthers*, *supra*, slip op. 2.[2] Participating states are not required to provide medical assistance to any other group of persons.[3] Under certain limited circumstances, however, participating states may provide Medicaid benefits to persons who would be eligible for categorical assistance except for the amount of their income and resources (*i.e.*, the "medically needy"). A state is entitled to receive federal financial assistance for providing Medicaid benefits to a person who is ineligible for benefits under one of the categorical assistance programs only if that person has incurred medical expenses equal to or greater than the difference between his countable income and the medically needy income standard—a standard which cannot exceed 133⅓% of the amount that would be paid to a family of the same size under the state Aid to Families with Dependent Children (AFDC) program (42 U.S.C. 601 *et seq.*).

---

[2] The so-called "209(b) option" creates an exception to this general requirement, but is immaterial in the present context. See 42 U.S.C. 1396a(f); see generally *Schweiker* v. *Gray Panthers*, *supra*, slip op. 3-4 & nn.4-6.

[3] As is true of most general statements concerning this "intricate" statute (*Schweiker* v. *Gray Panthers*, *supra*, slip op. 8), there are several exceptions to the statement in the text. See, *e.g.*, Act of Dec. 31, 1973, Pub. L. No. 93-233, Section 13(c), 87 Stat. 965, 42 U.S.C. 1396a note (medicaid eligibility for mandatory state supplementary payment recipients); see generally 42 C.F.R. Part 435, Subpart B. None of these exceptions is material in this case.

42 U.S.C. 1396a(a)(10)(C), 1396a(a)(17)(D), and 1396b(f).[4]

In 1972, Congress replaced three of the four state-administered categorical assistance programs with a new federal program called Supplemental Security Income for the Aged, Blind, and Disabled (SSI), 42 U.S.C. 1381 *et seq.* *Schweiker* v. *Gray Panthers*, *supra*, slip op. 3.[5] Although the SSI program establishes a "Federal guaranteed minimum income level" for the aged, blind, and disabled (*Schweiker* v. *Wilson*, No. 79-1380 (Mar. 4, 1981), slip op. 2), the states may supplement the minimum benefit payment provided under the federal program. See 42 U.S.C. 1382e.[6] If a state chooses to

---

[4] Although the term is somewhat misleading, this is sometimes referred to as a "spend down" requirement. The statute only requires the "medically needy" applicant to "incur" these medical expenses. Eligibility is not dependent on actual payment of the debt during the relevant period.

[5] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. See Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to the Blind (AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.* The AFDC program (42 U.S.C. 601 *et seq.*) is still administered by the states and is only partially funded by the federal government.

[6] In most states, adoption of the SSI program resulted in an increase in benefits for aged, blind, and disabled categorical assistance recipients. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 78-91, Tables 3 & 4 (1972); see also *id.* at 75; H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 199 (1971). To prevent any reduction in benefits to categorical assistance recipients in those states that had maintained higher benefit levels than established in the SSI program, Congress required those states to make supplemental payments under certain

make supplementary payments (see 42 U.S.C. 1396d(j)) to SSI benefit recipients or to persons who would be eligible for SSI benefits except for the amount of their income and resources, the state also may provide Medicaid benefits to those persons under limited circumstances. 42 U.S.C. 1396a(a)(10)(C)(III), 1396b(f)(4)(C).[7]

2. Massachusetts has chosen to participate in the Medicaid program and to provide Medicaid benefits to the "medically needy" (see 42 U.S.C. 1396a(a)(10)(C)), but only to those persons for whom it will receive federal financial assistance (see 42 U.S.C. 1396b(f)). Massachusetts also has chosen to make supplementary payments to persons eligible for SSI benefits or who would be eligible for SSI benefits except for their income and resources (see 42 U.S.C. 1382e), and to provide Medicaid benefits to those persons (see 42 U.S.C. 1396a(a)(10)(C)(III)). At least in some cases, 133⅓% of the appropriate Massachusetts AFDC payment amount is less than the state supplementary payment level.[8]

---

circumstances. Act of July 9, 1973, Pub. L. No. 93-66, Section 212, 87 Stat. 155-158, as amended by the Act of Dec. 31, 1973, Pub. L. No. 93-233, Section 10, 87 Stat. 957-958, 42 U.S.C. 1382 note; see 119 Cong. Rec. 22606 (1973) (remarks of Sen. Long); *id.* at 22645 (remarks of Rep. Mills); S. Rep. No. 93-249, 93d Cong., 1st Sess. 24-25 (1973).

[7] A state is entitled to federal financial assistance for providing Medicaid benefits to a state supplementary payment recipient (who is ineligible for SSI benefits) only if his gross income is less than 300% of the applicable SSI income limitation. 42 U.S.C. 1396b(f)(4)(C).

[8] For example, after July 1979, the monthly benefit level for an aged couple under the Massachusetts optional supplementary payment program was $513.78. Complaint, Exh. B; see also App. A, *infra*, 2a. Thus, if the couple's SSI benefit payment and any other countable income had amounted to

3. Appellees filed suit in the United States District Court for the District of Massachusetts, challenging the medically needy income limitations prescribed in Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) as violative of the equal protection component of the Fifth Amendment, and the corresponding state provisions as violative of the Equal Protection Clause of the Fourteenth Amendment. Complaint, Count I.[9] Each of the appellees

---

less than $513.78, the state would make a supplemental payment equal to the difference between $513.78 and the couple's total income. Compare App. A, *infra*, 7a. The SSI monthly benefit amount for an aged couple after July 1979 was approximately $312 (see 45 Fed. Reg. 31782 (1980); see also App. A, *infra*, 7a); it was increased to approximately $357 in July 1980 (45 Fed. Reg. 31782 (1980)). The Massachusetts medically needy income standard after December 1979 was $400 for a family of two. See Complaint, ¶ 16 & Exh. D; see also App. A, *infra*, 2a. Thus, a couple with monthly income of $514.78 could only qualify for medical assistance if they incurred medical expenses in excess of $114.78. Massachusetts uses a six-month accounting period to determine Medicaid eligibility for the "medically needy," and therefore the hypothetical couple would need to incur medical expenses of $688.68 to qualify for assistance in any six-month period. See Complaint, ¶ 3. All covered expenses in excess of $688.68 are paid by the state.

[9] Appellees also challenged the federal and state provisions requiring them to "apply for and accept all Social Security benefits for which they are eligible as a condition of application for SSI and Medicaid, 42 U.S.C. § 1382(e)(2); 20 C.F.R. § 416.230; 42 C.F.R. § 435.603; MPAPM, ch. IV, § B, p. 4 * * *" as violative of the equal protection requirements of the Fifth and Fourteenth Amendments. Complaint, Count II. In Count III of their complaint, appellees charged that Massachusetts' six-month accounting period for determining the eligibility of the medically needy is inconsistent with the requirements of the Social Security Act (see App. A, *infra*, 3a n.3).

or his spouse has been employed at some point in his career and paid "Social Security taxes" (App. A, *infra*, 2a). Each of the appellees (or his spouse) receives Federal Old-Age, Survivors, and Disability Insurance benefits (OASDI), 42 U.S.C. 401 *et seq.*—benefits in amounts that render him ineligible for SSI or state supplementary payments.[10] Because the Massachusetts supplementary payment standard is higher than 133⅓% of the Massachusetts AFDC payment level in some cases, payment of the medical expenses required to qualify for medical assistance leaves some "medically needy" persons (such as appellees) with less income for non-medical expenses than "categorically needy" persons. Appellees' complaint is essentially that since they worked for substantial periods of time and paid Social Security taxes, it was wholly irrational for Congress to treat them less favorably under the Medicaid program than welfare recipients (*i.e.*, the categorically needy), who may or may not ever have worked or paid any taxes.[11]

---

[10] Many of the appellees presumably are eligible for benefits under the Medicare program (42 U.S.C. 1395 *et seq.*) and at least some of their medical expenses are paid under that program. See Complaint, ¶ 38. The plaintiff class certified by the district court, however, includes only those OASDI beneficiaries who have incurred medical expenses in addition to those paid under the Medicare program or by some other third-party such as a private insurance company. See App. D, *infra*, 23a-24a.

[11] In other words, the appellees in this case, who paid Social Security taxes during their work careers and now receive OASDI benefits, are classified as "medically needy" rather than "categorically needy" because their total income is greater than that of SSI, AFDC, and state supplementary

On cross motions for summary judgment as to Counts I and II of the Complaint, the district court held (App. A, *infra*, 20a) "the Massachusetts Medicaid program unconstitutional insofar as it forces Social Security recipients to spend down [*i.e.*, incur medical expenses that may reduce their income to an amount] below Supplemental Security Income levels before receiving medical benefits." [12] The district court entered an order granting appellees' motion for partial summary judgment (App. B, *infra*,

---

payment recipients (*i.e.*, the categorically needy). Since the appellees are, therefore, ineligible for benefits under any of the categorical assistance programs, they are not automatically entitled to Medicaid benefits and may qualify for Medicaid benefits as "medically needy" persons only if they incur medical expenses in excess of the difference between their incomes and 133⅓% of the relevant AFDC payment amount (*i.e.*, the medically needy income standard). See 42 U.S.C. 1396a(a)(10)(A) and (C), 1396b(f). This, they claimed, results in irrational discrimination between themselves and the categorically needy, who are automatically eligible for Medicaid benefits. Because of the so-called "spend down" requirement (see note 4, *supra*) applicable to the medically needy, but not to the categorically needy, appellees asserted that they were left with less money, after payment of medical expenses, than the categorically needy.

It should be noted, however, that although appellees may be left with less money for non-medical expenses than SSI recipients (*i.e.*, aged, blind, or disabled categorically needy persons), they are necessarily left with 33⅓% *more* money for non-medical expenses than AFDC benefit recipients.

[12] Since it is clear that 133⅓% of the Massachusetts AFDC payment level (*i.e.*, the medically needy income standard) is higher than the federal SSI benefit levels, the district court's reference to "Supplemental Security Income levels" was almost certainly intended to refer to state supplementary payment levels.

21a).[13] In a supplemental order, the district court sought to clarify the nature of its holding, stating (App. C, *infra*, 22a):

> It is the confluence of federal and state requirements which renders the Massachusetts program unconstitutional. It is that federal-state program which this court held to be unconstitutional, and not merely the Massachusetts medicaid statute.

Finally, on April 9, 1981, the district court directed that final judgment be entered on Counts I and II of the Complaint and modified its prior decision by expressly holding Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) unconstitutional (App. E, *infra*, 25a): "[T]he court states that its ruling holds unconstitutional, in addition to the Massachusetts Medicaid income eligibility standards applied to the plaintiff class, the federal statute limiting Medicaid reimbursement, 42 U.S.C. section 1396b(f)."[14]

---

[13] While the district court purported to grant appellees' motion for partial summary judgment on Counts I and II of the Complaint, the court never discussed the claim in Count II that requiring appellees "to apply for and accept Social Security benefits" as a condition of eligibility for both SSI benefits and Medicaid benefits violated the equal protection requirements of the Fifth and Fourteenth Amendments. We do not believe that the district court intended to invalidate a federal statute (42 U.S.C. 1382(e)(2)) and implementing regulations (20 C.F.R. 416.230; 42 C.F.R. 435.603) without discussion. In any event, Congress reasonably has chosen to treat SSI and Medicaid as assistance programs of last resort and, therefore, has required individuals to seek assistance from a program that is partially funded by their specific contributions or from other sources before resorting to programs that are funded entirely from general revenues. There is no constitutional infirmity in such a requirement.

[14] The district court's opinion (App. A, *infra*, 1a-20a) and its initial order (App. B, *infra*, 21a) were issued on

THE QUESTION IS SUBSTANTIAL

The district court has invalidated on constitutional grounds a critical component of the Medicaid Act, as applied in Massachusetts. The district court's legal analysis, however, is directly applicable in at least 15 other states and could result in an increase of federal and state expenditures for the Medicaid program of more than $150 million in fiscal year 1983 alone.[15]

The district court's constitutional ruling is erroneous. First, the major premise of the district court's analysis is that the difference in income standards for the "medically needy" (including Social Security benefit recipients like appellees) and

---

November 21, 1980. The order clarifying the decision and initial order (App. C, *infra*, 22a) was issued on December 22, 1980. Following the December 22, 1980 order, the government filed a notice of appeal to this Court (App. F, *infra*, 26a). Because there was still considerable uncertainty, however, as to whether the court had invalidated a federal statute, and, if so, which one, the parties sought further clarification. On April 9, 1981, the district court issued the judgment from which the instant appeal is taken, leaving no doubt that Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) was held unconstitutional. Because the time for docketing the appeal from the December 22 order in this Court had expired, the government filed a second notice of appeal. See *United States* v. *Clark*, 445 U.S. 23, 26 n.2 (1980).

The district court has not yet granted any relief. Under 28 U.S.C. 1252, however, this Court may review both interlocutory and final judgments.

[15] Because the district court's holding rests on the relationship between the AFDC payment level and the state supplementary payment level, it is difficult to estimate with precision the financial impact of the district court's decision.

the "categorically needy" established by Section 1903 (f) (42 U.S.C. 1396b(f)) was "the result of a legislative accident" (App. A, *infra*, 19a). See App. A, *infra*, 12a, 13a-19a. That premise is demonstrably wrong. The medically needy income limitation was adopted only after careful consideration and despite severe and repeated criticism. Moreover, Congress adopted the medically needy income limitation with full knowledge that, in some states, this limitation would compel the medically needy to incur medical expenses that could reduce their incomes to a level below the categorical assistance levels. Second, while the district court's view that OASDI benefit recipients such as appellees (App. A, *infra*, 8a) "with long histories of paying Social Security taxes" should not be forced to "live on less than those who have paid little or no tax" (*ibid.*) is a plausible expression of public policy, it provides no basis for invalidating the different policy judgment of Congress. This Court's decisions make it plain that policy judgments of this sort are for the legislature, and have no place in equal protection analysis. See, *e.g.*, *Schweiker* v. *Wilson*, No. 79-1380 (Mar. 4, 1981); *United States Railroad Retirement Board* v. *Fritz*, No. 79-870 (Dec. 9, 1980). Accordingly, review by this Court of the district court's invalidation of the federal statutory provision is warranted.

1. *a.* Income limitations under the Medicaid program, as enacted in 1965, were left almost entirely to the discretion of participating states.[16] See H.R.

---

[16] Before the SSI statute was enacted, the states administered the categorical assistance programs for the aged, blind, and disabled as well as those for families with dependent children. Under each of the old categorical assistance pro-

Rep. No. 213, 89th Cong., 1st Sess. 67 (1965); S. Rep. No. 404, 89th Cong., 1st Sess. 77-78 (1965). Congress initially relied on the presumed desire of the states to limit their own expenditures under the Medicaid program to contain federal expenditures, as it had done with respect to the categorical assistance programs. Nevertheless, from the beginning Congress conceived of Medicaid as essentially a limited public assistance program for the very "needy." See H.R. Rep. No. 213, *supra*, at 66; S. Rep. No. 404, *supra*, at 77.[17] And, consistent with this limited objective, Congress soon recognized the imprudence of relying on the states to limit expenditures in the Medicaid context and began to seek ways to impose substantial limits on federal

---

grams, the individual states set both the "standard of need" and the "level of benefits." See generally *Jefferson* v. *Hackney*, 406 U.S. 535, 541, 542 (1972); *Rosado* v. *Wyman*, 397 U.S. 397, 408-409 (1970). In establishing the income standards for the categorical assistance programs, of course, the states also established the income requirements for the categorically needy under the Medicaid program (see 42 U.S.C. 1396a(a)(10)(A)). The Medicaid statute prescribed no income limitation for the medically needy.

[17] "Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under * * * [the categorical assistance programs]. These people are *the most needy* in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to *the less needy* than those who would be eligible for aid under the various *other* categories of public assistance." H.R. Rep. No. 213, *supra*, at 66 (emphasis added).

financial participation. H.R. Rep. No. 2224, 89th Cong., 2d Sess. 1-3 (1966).[18]

b. One year after the effective date of the Medicaid statute, Congressman Mills introduced an administration sponsored bill that would have made significant changes in the categorical assistance programs as well as the Medicaid program. H.R. 5710, 90th Cong., 1st Sess. (1967); see 113 Cong. Rec. 3899 (1967).[19] Two of the provisions of H.R. 5710 are of particular relevance here. Under Section 220 of the bill, a state participating in the Medicaid program would have been entitled to receive federal financial assistance for providing Medicaid benefits only to those persons whose income, after deduction of incurred medical expenses, was less than 150% of *the highest* of the state's cate-

---

[18] "The Committee on Ways and Means at this time, has been unable to develop a formula applying specific fiscal limitations as to Federal participation in title XIX which would be both effective and equitable. It has given consideration to a number of proposed methods of limiting future Federal financial liability with respect to overall limitation of State plans and of eligibility limitations on the income of individuals and families for whom payments might be made with Federal financial participation, particularly those with attachments to the labor force that generally afford access to health insurance protection. Your committee wishes to make its intention clear, however, that such a formula may be developed and it therefore now cautions the States to avoid unrealistic levels of income and resources for title XIX eligibility purposes. Your committee will continue to study appropriate means of achieving these goals * * *." H.R. Rep. No. 2224, *supra*, at 2-3; see also *id.* at 26-27 (supplemental views of Rep. Curtis).

[19] The administration sponsored bill is reprinted in *President's Proposals for Revision in the Social Security System: Hearings on H.R. 5710 Before the House Comm. on Ways and Means*, 90th Cong., 1st Sess. 26-77 (1967) (*"1967 House Hearings"*).

gorical assistance income standards. See *1967 House Hearings* 65, 91.[20] Under Section 202 of the administration bill, all states would have been required annually to revise standards of need under each of the categorical assistance programs to reflect changes in the cost of living and, in some circumstances, required to pay 100% of the standard of need under each of the programs. See *1967 House Hearings* 59, 90. In support of Section 202, the Department of Health, Education, and Welfare (now Health and Human Services) explained that "33 States provide less support for needy children [under the AFDC program] than the standards the States themselves have set as necessary to meet basic human needs" (*1967 House Hearings* 118).[21] In January 1965, there were 21 states that paid less than 75% of the standard of need established for a family of four under the AFDC program. *Id.* at 119.

Nevertheless, after extensive study the House Committee rejected the administration's proposed 150% limitation and reported out a substantially revised bill. H.R. 12080, 90th Cong., 1st Sess. (1967); see 113 Cong. Rec. 23048 (1967) (remarks of Rep. Mills).[22] Section 220 of the House bill provided that

---

[20] This provision would have had no effect at all on the categorically needy since their income was necessarily less than 150% of the highest categorical assistance standard. It could only have been intended to limit the scope of coverage provided to the "medically needy."

[21] See also *1967 House Hearings* 184; *Jefferson* v. *Hackney*, 406 U.S. 535, 537 & n.3 (1972); *Dandridge* v. *Williams*, 397 U.S. 471, 481 & n.13, 483 n.15 (1970).

[22] H.R. 12080 is reprinted in *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess. 3-209 (1967) ("*1967 Senate*

federal financial assistance would be available to the states under the Medicaid program only for expenditures made on behalf of persons whose income, after deduction of medical expenses, was less than 133⅓% of the amount that would be *paid* to a family of the same size under the AFDC program or, in some circumstances, a still lower figure. See *1967 Senate Hearings* 145; H.R. Rep. No. 544, 90th Cong., 1st Sess. 5, 18, 118-119, 183 (1967); 113 Cong. Rec. 23055 (1967) (remarks of Rep. Mills).[23] The House Committee specifically noted that AFDC income limits were generally the lowest of all the categorically needy program limits. H.R. Rep. No. 544, *supra*, at 119. Indeed, Congressman Mills, Chairman of the House Ways and Means Committee and co-sponsor of H.R. 12080, pointed out that the AFDC standard had been selected precisely "because" it was generally the lowest. See 113 Cong. Rec. 23055 (1967).

The limitation on federal participation in the Medicaid program was, as the district court noted (App. A, *infra*, 13a), "but one small part of a Social Security bill containing wide-ranging revisions

---

Hearings"). The House Committee also rejected the administration's proposal to require the states to pay 100% of the standard of need established under the categorical assistance programs. See *Rosado* v. *Wyman*, *supra*, 397 U.S. at 410.

[23] Thus, in the 21 states that paid less than 75% of the AFDC standard of need, the House provision would have established a medically needy income limitation that was even lower than the AFDC standard of need. This might have resulted in the denial of Medicaid benefits for the categorically needy as well as the medically needy. The House bill did not, however, modify Section 1902(a)(10)(A) of the Act (42 U.S.C. 1396a(a)(10)(A)), which required the states to provide Medicaid benefits to all of the categorically needy.

in several programs." It was recognized, however, to be a very significant provision and was severely criticized on the House floor.[24] Indeed, Congressman Burton criticized the provision on policy grounds that are virtually indistinguishable from those which underlie the district court's decision in this case (113 Cong. Rec. 23092 (1967)):

> Under the proposed title XIX income limitation we have people drawing old-age security benefits [OASDI]—whose income [after deduction of medical expenses] is less than someone drawing old-age assistance, and they will be precluded—under the clear language of this bill—from getting equivalent medical care that is received by their better-off counterparts on OAA [now SSI]. I do not think that is a thoughtful legislative product.

Congressman Burton challenged "anyone to take issue with those statements" (*ibid.*). No one did because the statements were factually accurate. Supporters of the provision, nonetheless, were warm in its defense. See 113 Cong. Rec. 23061-23062 (1967) (remarks of Rep. Byrnes); *id.* at 23084-23085 (remarks

---

[24] See 113 Cong. Rec. 23065 (1967) (remarks of Rep. King); *id.* at 23077 (remarks of Rep. Burke); *id.* at 23082 (remarks of Rep. Vanik); *id.* at 23083 (remarks of Rep. Gilbert); *id.* at 23084 (remarks of Rep. Bingham); *id.* at 23087 (remarks of Rep. Halpern); *id.* at 23092 (remarks of Rep. Burton); *id.* at 23093 (remarks of Rep. Ryan); *id.* at 23104 (remarks of Rep. Bingham); *id.* at 23125 (remarks of Rep. Boland); *id.* at 23128 (remarks of Rep. Kastenmeier); *id.* at 23131 (remarks of Rep. Farbstein); see also *id.* at 22781 (remarks of Rep. Bingham); *id.* at 22784 (remarks of Rep. Gilbert); *ibid.* (remarks of Rep. Ottinger); *id.* at 22785 (remarks of Rep. Tiernan); *ibid.* (remarks of Rep. Scheuer); *ibid.* (remarks of Rep. St. Germain).

of Rep. Hanley); *id.* at 23090 (remarks of Rep. Stratton); *id.* at 23091 (remarks of Rep. McCarthy); *id.* at 23093 (remarks of Rep. Mills); *id.* at 23105 (remarks of Rep. Taft); see also *id.* at 22783 (remarks of Rep. Quillen).

Despite Congressman Burton's protestation, H.R. 12080 was passed by the House and referred to the Senate, which in turn referred it to the Senate Finance Committee.

c. The Department of Health, Education, and Welfare urged the Senate Finance Committee to amend H.R. 12080 in conformity with the administration sponsored bill (H.R. 5710). See *1967 Senate Hearings* 417-712. Wilbur Cohen, Undersecretary of Health, Education, and Welfare, specifically urged the Committee to adopt the administration's standard (150% of the highest categorical assistance income standard) for limiting federal participation in the Medicaid program. *1967 Senate Hearings* 282. In urging rejection of the 133⅓% of AFDC payment standard, Cohen specifically pointed out that, in states such as Indiana and Texas, 133⅓% of the AFDC payment amount was less than even the AFDC standard of need, and therefore might result in exclusion of some of the categorically needy, a result that he suggested probably was not intended.[25] See *1967 Senate Hearings*

---

[25] The district court dismissed Cohen's testimony as immaterial, stating (App. A, *infra*, 13a-14a n.16; citation omitted):

> Undersecretary Cohen did point out that the four-thirds rule [*i.e.*, 133⅓% of the AFDC payment amount] would in some states force a spend-down below the cash assistance level. But he was not testifying about the medically needy-categorically needy discrepancy. The Undersecretary's complaint was that the four-thirds rule would, due

280 (Indiana), 282 (Texas).[26]

Following these hearings, the Senate Committee rejected both the House standard and the proposed administration standard, adopting instead a completely different formula for limiting federal expenditures under the Medicaid program. Under the proposed Senate formula, participating states would not receive federal financial assistance for Medicaid expenditures made on behalf of any person whose income was greater than 150% of the OAA cash assistance standard (which was generally the highest of the cash assistance standards, see 113 Cong. Rec. 33170 (1967) (remarks of Sen. Long)).[27] Effective

---

to the vagaries of state AFDC programs, exclude some of the categorically needy from Medicaid coverage.

The court offered no explanation of how the Senate Finance Committee could have listened to Cohen "point out that the four-thirds rule would in some states force a spend-down below the cash assistance level" and nevertheless remain unaware that "the four-thirds rule [*i.e.* 133⅓% of the AFDC payment amount] would in some states force a spend-down below the cash assistance level." There is no such explanation. That Cohen chose to make his point in the strongest fashion by focusing on the possible exclusion of some of the categorically needy is simply beside the point.

[26] Further, in connection with his recommendation that H.R. 12080 be amended to require the states to pay 100% of the standard of need established under the categorical assistance programs, Cohen emphasized that many states failed to pay 100% of the standard of need under the AFDC program. *1967 Senate Hearings* 259; see also *id.* at 289 (charts indicating that in January 1967 19 jurisdictions paid less than 75% of the standard of need established under the AFDC program, but only 16 states paid less than 100% of the standard of need established under the OAA program).

[27] Like the Administration's proposed standard (see note 20, *supra*), therefore, the Senate's 150% of the OAA in-

July 1, 1969, however, the federal share of Medicaid expenditures for all of the medically needy would be substantially less than the federal share of Medicaid expenditures on behalf of the categorically needy. S. Rep. No. 744, 90th Cong., 1st Sess. 177 (1967).[28] It is impossible to determine what the impact of the Senate bill would have been if it had been adopted. But see 113 Cong. Rec. 33168 (1967) (remarks of Sen. Javits) (expressing the view that states would eliminate programs for the medically needy). It is plain, however, that the Senate proposal was intended to discourage participating states from extending coverage to the medically needy. See generally 113 Cong. Rec. 33171 (1967) (remarks of Sen. Long).

On the floor of the Senate, Senator Kuchel offered an amendment that would have adopted the administration sponsored limitation on federal financial participation (*i.e.*, 150% of the highest categorical assistance income standard). See 113 Cong. Rec. 32845-32846 (1967) (remarks of Sen. Kuchel). Urging acceptance of the Kuchel amendment, Senator Javits, one of the co-sponsors of the amendment (113 Cong. Rec. 33167 (1967)), vigorously criticized the committee bill on the ground that it discrimi-

---

come standard would have had no effect on the Medicaid eligibility of the categorically needy in most states.

[28] Under the Senate bill the federal share of Medicaid expenditures on behalf of the medically needy was to be determined by "squaring" the percentage of the state expenditures for the categorically needy that the federal government paid. S. Rep. No. 744, *supra*, at 176-177, 178 (Table B). "Thus, States whose Federal medical assistance percentage is 50 percent under present law would, under the committee bill, receive only 25 percent Federal matching toward the costs of the medically needy." *Id.* at 177.

nated against the medically needy. See 113 Cong. Rec. 33168, 33169 (1967). Senator Long responded (*id.* at 33169): "We are talking here about the people who are not on the public assistance rolls. That is the area in which we think savings should be made." Senator Long acknowledged that the bill discriminated against the medically needy (*ibid.*), but explained (*id.* at 33171): "The commitee bill encourages the State to concentrate its medical assistance for those who are most in need, those who qualify for public welfare assistance." Thus, contrary to the implications of the district court opinion (App. A, *infra*, 17a), the Senate rejected Senator Javits' discrimination argument when it rejected the Kuchel amendment. See 113 Cong. Rec. 33174 (1967).

d. After conference, the House 133⅓% AFDC payment standard was adopted, *with an express exception for the categorically needy.* H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. 63 (1967). In the House debates on the Conference Report several Congressmen reiterated their opposition to the AFDC payment standard.[29] In the Senate, Senator Kennedy noted that the 133⅓ AFDC limitation would result in a medically needy income standard of about $80 per month for a family of four in Mississippi. 113 Cong. Rec. 36784 (1967). More specifically, Senator Mondale quoted Undersecretary Cohen's testimony before the Finance Committee, indicating that in both Indiana and Texas 133⅓% of the AFDC payment amount would be less than the standard of need established under even the AFDC pro-

---

[29] See 113 Cong. Rec. 36380 (1967) (remarks of Rep. Burton); *id.* at 36381 (remarks of Rep. Gilbert); *id.* at 36385 (remarks of Rep. Reid); *id.* at 36387 (remarks of Rep. Ryan); *id.* at 36389 (remarks of Rep. Farbstein).

gram. *Id.* at 36819. Nevertheless, Congress approved the conference report and enacted Section 1903(f) (42 U.S.C. 1396b(f)) into law.

2. As the foregoing summary of the legislative history clearly demonstrates, the primary purpose of Section 1903(f) was to substantially limit federal financial support for the medically needy. H.R. Rep. No. 544, *supra*, at 117-119; S. Rep. No. 744, *supra*, at 176-177; see generally Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* 8-9, 23, 56 (1968). Congress was well aware that the 133⅓% AFDC payment standard would, in some cases, require the medically needy to incur medical expenses that could reduce their income to an amount less than categorical assistance standards. Congress nevertheless adopted the provision. Quite plainly, Congress would not have expressly exempted the categorically needy from the limitations imposed by Section 1903(f) if it had not realized that 133⅓% of the AFDC payment level would sometimes be lower than the categorical assistance standards. Thus, "Congress was aware of what it was doing, and the legislative history does not demonstrate that the plain language was not intended." *Maine* v. *Thiboutot*, 448 U.S. 1, 8 (1980); see *Schweiker* v. *Wilson*, No. 79-1380 (Mar. 4, 1981), slip op. 15; *United States Railroad Retirement Board* v. *Fritz*, No. 79-870 (Dec. 9, 1980), slip op. 12.[30]

---

[30] In 1969, four bills were introduced to repeal the 133⅓% AFDC payment standard. H.R. 618, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 69 (1969)); H.R. 1352, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 85 (1969)); H.R. 3272, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 652 (1969)); H.R. 8283, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 5382 (1969)). None of those bills was reported out of committee.

Congress could, of course, have eliminated all federal financial assistance for state expenditures on behalf of the medically needy or reduced the federal share of Medicaid expenditures for both the categorically needy and the medically needy. See, *e.g.*, *United States Railroad Retirement Board* v. *Fritz*, *supra*, slip op. 7; *Flemming* v. *Nestor*, 363 U.S. 603, 610-611 (1960).[31] Instead, it sought to preserve Medicaid assistance as an element of the benefit package provided for the categorically needy, while maintaining substantially more limited benefits for persons whose gross incomes made them "less needy" (*i.e.*, the medically needy). The medically needy have greater income and resources than the categorically needy and therefore are better able to provide for themselves (by, for example, purchasing private health insurance or optional coverage under Medicare before incurring substantial medical expenses).[32] It is

---

[31] In *Fullington* v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F. Supp. 500 (D. Colo. 1970), this Court rejected an equal protection challenge to Colorado's decision to provide Medicaid benefits only to the categorically needy and not to the medically needy. See also *Freeman* v. *Parham*, 475 F.2d 185 (5th Cir. 1973).

[32] The district court acknowledged that at least one of Congress' purposes in adopting the 133⅓% limitation was to encourage the purchase of private health insurance (App. A, *infra*, 20a). The court nonetheless dismissed that purpose as insufficient to support Section 1903(f) (App. A, *infra*, 20a):

> The expressed purpose to prevent duplication of middle income families' private health insurance, however, cannot support a rule which cuts so deeply into the basic needs of some of society's poorest individuals.

If this were a First Amendment case, the district court's "overbreadth" analysis might be appropriate. But it has no

no answer to say, as did the district court, that, after the medically needy have incurred medical expenses, they are indistinguishable from the categorically needy. Congress reasonably concluded that the relevant time for comparing the circumstances of the two groups is before medical expenses are incurred—when the medically needy can take steps to assure that potential medical expenses can be paid but the categorically needy cannot.

That one might reasonably maintain that persons such as appellees "with long histories of paying Social Security taxes" are no less deserving than the categorically needy is constitutionally irrelevant. Congress has expressed a different policy judgment in making the categorically needy eligible for Medicaid without more, while requiring the medically needy, including OASDI recipients, to incur certain medical expenses before qualifying for assistance. As this Court pointed out in *United States Railroad Retirement Board* v. *Fritz*, *supra*, slip op. 12:

> The "task of classifying persons for . . . benefits . . . inevitably requires that some persons who have an almost equally strong claim to favorite treatment be placed on different sides of the line," *Mathews* v. *Diaz*, 426 U.S. 67, 83-84 (1970), and the fact the line might have been drawn differently at some points is a matter

---

place in a case such as this involving economic policy choices of Congress. See *Dandridge* v. *Williams*, 397 U.S. 471, 484-485 (1970) (citations omitted): "For this Court to approve invalidation of * * * economic or social regulation as 'overreaching' would be far too reminiscent of an era when the Court thought the Fourteenth Amendment gave it power to strike down * * * laws 'because they may be unwise, improvident, or out of harmony with a particular school of thought.' That era long ago passed into history."

for legislative, rather than judicial, consideration.

See also *Schweiker* v. *Wilson*, *supra*, slip op. 17 & n.23 ("Awarding this type of benefits inevitably involves the kind of line-drawing that will leave some comparably needy person outside the favored circle."); *Califano* v. *Boles*, 443 U.S. 282, 293 (1979) ("We have repeatedly stated that there is no constitutional requirement that 'a statutory provision . . . filte[r] out those, and only those, who are in the factual position which generated the congressional concern reflected in the statute'."); *Califano* v. *Aznavorian*, 439 U.S. 170, 174-175 (1978); *Cleland* v. *National College of Business*, 435 U.S. 213, 220-222 (1978); *Idaho Department of Employment* v. *Smith*, 434 U.S. 100 (1977); *Califano* v. *Jobst*, 434 U.S. 47, 53 (1977) ("General Rules are essential if a fund of this magnitude is to be administered with a modicum of efficiency, even though such rules inevitably produce seemingly arbitrary consequences in some individual cases [or classes of cases]."); *Weinberger* v. *Salfi*, 422 U.S. 749 (1975); *Dandridge* v. *Williams*, 397 U.S. 471, 485-487 (1970).

Public assistance legislation of the kind at issue in this case is entitled to a "strong presumption of constitutionality." *Schweiker* v. *Wilson*, *supra*, slip op. 17, quoting *Mathews* v. *De Castro*, 429 U.S. 181, 185 (1976); see *Califano* v. *Aznavorian*, *supra*, 439 U.S. at 175; *Califano* v. *Torres*, 435 U.S. 1, 5 (1978). Congress and the state legislatures must be accorded "wide[] latitude in choosing among competing demands for limited public funds." *Maher* v. *Roe*, 432 U.S. 464, 479 (1977); see *Schweiker* v. *Wilson*, *supra*, slip op. 17; *Califano* v. *Torres*, *supra*, 435 U.S. at 5; *Idaho Department of Employment* v. *Smith*,

supra, 434 U.S. at 101; *Jefferson* v. *Hackney*, 406 U.S. 535, 546, 549 (1972). That Congress could have accomplished its goals in other ways is beside the point. See *Schweiker* v. *Wilson*, *supra*, slip op. 13; *Cleland* v. *National College of Business*, *supra*, 435 U.S. at 220-221. When, as here, the "statutory classification does not itself impinge on a right or liberty protected by the Constitution, the validity of [the] classification must be sustained unless 'the classification rests on grounds wholly irrelevant to the achievement of [any legitimate governmental] objective'." *Harris* v. *McRae*, *supra*, 448 U.S. at 322, quoting *McGowan* v. *Maryland*, 366 U.S. 420, 425 (1961); see *Vance* v. *Bradley*, 440 U.S. 93, 97 (1979). And, in considering equal protection challenges to public assistance legislation, the "broad legislative classification[s] must be judged by reference to characteristics typical of the affected classes rather than by focusing on selected, atypical examples." *Califano* v. *Jobst*, *supra*, 434 U.S. at 55.

Viewed in light of these well-established principles, Section 1903(f) clearly passes the test of minimum rationality. Indeed, reversal of the judgment in this case follows *a fortiori* from *Fullington* v. *Shea*, *supra*, in which this Court summarily affirmed the rejection of an equal protection challenge to Colorado's decision to provide Medicaid benefits to the categorically needy but not to provide any benefits at all to the medically needy, including, of course, OASDI benefit recipients like appellees. Requiring the medically needy to incur medical expenses that could reduce their remaining income to a level less than categorical assistance standards rationally furthers two of Congress' articulated goals. First, it reduces federal expenditures. Second, it encourages those who generally are in a better position to do so to purchase private

insurance or, in the case of most if not all of the appellees, to obtain optional Medicare coverage. The provision "reflects the assessment by Congress of the realities of * * * fiscal needs and priorities and represents use of an effective tool for imposing controls on potentially the greatest source of additional cost of the medical care program, namely, the services to the medically needy" (*Intergovernmental Problems in Medicaid, supra*, at 64). Thus, the distinction drawn between the categorically needy (*i.e.*, "the most needy") and the medically needy (*i.e.*, the "less needy") is perfectly reasonable. See, *e.g.*, *Schweiker* v. *Wilson, supra*, slip op. 17-18; *Califano* v. *Boles, supra*, 443 U.S. at 296 ("Congress [can] rationally choose to concentrate limited funds where the need is likely to be greatest."); *Fullington* v. *Shea*, 404 U.S. 963 (1971).[33] The district court therefore erred in holding Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) to be unconstitutional.

---

[33] The arguments accepted by the district court in this case "amount to the claim that had Congress been more careful, and had it fully thought out the relationship among the various sections, it might have acted differently." *Maine* v. *Thiboutot, supra*, 448 U.S. at 8 (footnote omitted). Such arguments, however, should be addressed to Congress, which is empowered to amend the statute if it agrees with appellees' policy concerns. *Ibid.*

CONCLUSION

Probable jurisdiction should be noted.[34]

Respectfully submitted.

LAWRENCE G. WALLACE
Acting Solicitor General

STUART E. SCHIFFER
Acting Assistant Attorney General

GEORGE W. JONES
Assistant to the Solicitor General

WILLIAM KANTER
BRUCE G. FORREST
Attorneys

JULY 1981

---

[34] In light of this Court's prior decisions in this area, and especially its summary affirmance in *Fullington* v. *Shea*, *supra*, the Court may wish to consider summary reversal.

APPENDIX A

UNITED STATES DISTRICT COURT
D. MASSACHUSETTS

Nov. 21, 1980

GEORGE HOGAN ET AL., PLAINTIFF

v.

PATRICIA HARRIS ET AL., DEFENDANTS

Civ. A. No. 80-883-T

OPINION

TAURO, District Judge.

This action challenges fundamental components in the "complex legislative mosaic" [1] of federal-state public assistance.[2] Plaintiffs are a group of aged and disabled Social Security recipients. Their complaint is that, under the Massachusetts Medicaid program, they receive substantially less income for basic non-medical living expenses than do identically situated aged and disabled persons whose source of support is Supplemental Security Income (SSI). This disparate treatment, they allege, creates an irrational classification which violates constitutional guarantees of equal protection.

---

[1] *City of New York* v. *Richardson*, 473 F.2d 923, 926 (2d Cir.), *cert. denied sub nom. Lavine* v. *Lindsay*, 412 U.S. 950, 93 S.Ct. 3012, 37 L.Ed.2d 1002 (1973).

[2] Plaintiffs' causes of action arise under 42 U.S.C. § 1983, and the Fifth and Fourteenth Amendments. They assert jurisdiction under 28 U.S.C. §§ 1331 and 1343.

Plaintiffs' grievances are best understood by examining the plight of Mr. and Mrs. Hunter, two of the named plaintiffs. Mr. Hunter worked for 41 years as a longshoreman, bartender, hotel clerk, and clothing alteration checker. He paid Social Security taxes during that period, and he and his wife now receive approximately $534.00 per month in Social Security benefits.

As Social Security beneficiaries, the Hunters are not automatically eligible for Medicaid assistance. Rather, the Massachusetts Medicaid program requires that they pay their own medical bills until they have "spent down" their income to a point where they have only $400.00 per month available for nonmedical living expenses. When they have done so, they become eligible for Medicaid assistance.

SSI beneficiaries, on the other hand, are not subject to such a "spend down" requirement before receiving Medicaid assistance. Instead, SSI recipients receive a "basic need" subsistence of $513.00 per month, in addition to having their medical needs met by Medicaid. This means that the Hunters have approximately $100.00 less per month to spend on food and clothing than do their SSI counterparts.

The irony of the Hunters' situation becomes apparent when one realizes that if their income were one dollar less per month, they would be considered eligible to become SSI beneficiaries. As such, they would receive full Medicaid coverage and be allowed $513.00 per month for their nonmedical living expenses. In other words, as SSI recipients they would not have to "spend down" to a $400.00 per month level in order to have their medical bills covered by Medicaid. The bottom line impact on the Hunters is that they, unlike their SSI counterparts, must exist

at a support level roughly 20% below the basic need standard established under SSI.

By their cross motions for partial [3] summary judgment, the parties raise the issue as to whether the Massachusetts Medicaid program is unconstitutional insofar as it forces Social Security recipients to "spend down" approximately $100.00 per month below Supplementary Security Income levels before becoming eligible to receive medical benefits.

I. *Background*

The classification at issue here arises from the convergence of three assistance programs: Old Age, Survivors, and Disability Insurance (OASDI), more commonly known as Social Security; [4] SSI; [5] and Medicaid.[6]

A) *Social Security*

Social Security, the basic social insurance program established by the Social Security Act of 1935, provides income security for the aged, the disabled, and their survivors and dependents. Essentially, eligibility depends on the existence of a disability, 42 U.S.C. § 423(a)(1), or the attainment of age 62, 42 U.S.C. § 402(a), and a sufficiently long history of payment of Social Security tax. 42 U.S.C. § 423 (c)(1) (disability); § 414(a) (old age.)

---

[3] Count III of the complaint, challenging Massachusetts' use of a six month accounting period in determining medically needy eligibility, is not put in issue by these cross motions.

[4] 42 U.S.C. §§ 401 et seq.

[5] 42 U.S.C. §§ 1381 et seq.

[6] 42 U.S.C. §§ 1396 et seq.

B) *Supplemental Security Income*

SSI, enacted in 1973 as Title XVI of the Social Security Act, is a cash assistance program of last resort for aged, blind, or disabled people who, for whatever reason, lack sufficient income to meet their basic needs. 42 U.S.C. §§ 1382c(a); 1382. Unlike Social Security, SSI is available without regard to work history or tax payments. An individual who is aged, blind, or disabled need only establish financial need in order to be eligible for SSI benefits. Financial need is established if an individual's income falls below SSI income standards. Benefits are provided sufficient to raise the individual's income to the minimum SSI level. 42 U.S.C. §§ 1382(b), 1382(e)(2), 1382a.

A basic minimum SSI level is set by Congress. But the states may, and in some cases must, raise the level by supplementing the federal benefits with state funds. *See* 42 U.S.C. § 1382e.

C) *Medicaid*

Medicaid, a federal state program established in 1965, pays for the cost of medical treatment for certain categories of the needy. The states formulate individual Medicaid plans and administer the programs, subject to federal statutory and regulatory requirements. 42 U.S.C. § 1396a. After paying out benefits, the states receive federal reimbursement for a certain percentage of total cost. 42 U.S.C. § 1396b.

The two basic groups of eligible Medicaid recipients are the "categorically needy" and the "medically needy." The categorically needy consist of recipients of SSI and Aid to Families with Dependent Children (AFDC). 42 U.S.C. § 1396a(a)(10)(A). The medically needy include those whose income is too high to

qualify them for AFDC or SSI, but too low to pay necessary medical expenses. 42 U.S.C. § 1396a(a)(10)(C). States which participate in Medicaid must provide benefits to the categorically needy. 42 U.S.C. § 1396a(a)(10)(A). On the other hand, participating states may or may not provide for the medically needy. 42 U.S.C. § 1396a(a)(10)(C).

In 1967, Congress added the provision which has led to the discrimination complained of here, namely, a limit on federal reimbursement for aid to the medically needy. Under 42 U.S.C. § 1396(f)(1)(B), the state may set maximum income levels for the medically needy no higher than 133⅓ percent (i.e. four thirds) of the AFDC income standards in force in that state.[7] Medically needy individuals with income higher than four thirds the AFDC standard may still receive benefits, but they must first "spend down" the difference between their income and the four thirds level on medical expenses. In contrast, SSI recipients automatically receive full Medicaid benefits without spending down. 42 U.S.C. § 1396b(f)(4). In Massachusetts, the result is that Social Security recipients with high medical expenses have less income to meet nonmedical living expenses than do SSI beneficiaries. This is so even though SSI payments are intended to be geared at a "base need" level.

II. *Facts*

The circumstances of the named plaintiffs illustrate the operation and impact of these programs. Plaintiffs George and Pearl Hogan have a combined monthly income of $646.60 in Social Security benefits.

---

[7] Strictly speaking, the state may set the maximum income level higher, but it will receive no federal reimbursement for the higher amount.

Mr. Hogan has a large cavity in his chest from surgical treatment of tuberculosis, and requires a daily antibacterial dressing change, which must be performed by a trained nurse. The cost of this treatment, along with the necessary medications and supplies, amounts to more than $1000 a month.

Henry and Celia Beberman together receive $668.10 a month in Social Security benefits. Mrs. Beberman, a 77-year-old victim of diabetes, osteomyelitis, deafness, and other ailments, needs daily assistance from a home health aid, and weekly visits by a nurse. Her medical expenses exceed $1300 a month.

Plaintiffs George and Cecilia Hunter have a combined monthly income of $534.70 in Social Security benefits. Mr. Hunter, 68 years of age, suffers from glaucoma and is a double amputee confined to a wheelchair. He must travel to Boston City Hospital twice a month for medical treatment, and can get there only by ambulance, at a cost of $162 per trip. In addition, he requires medication costing more than $50 a month.

Under the Massachusetts Medicaid Plan, the medically needy must pay their own medical expenses until they have spent down their income to $400 a month (i.e. four thirds of the Massachusetts AFDC standards for a family of corresponding size).[8] The Massachusetts SSI (i.e. categorically needy) eligibility levels, however, are considerably higher than $400 a month. Aged couples receive a maximum of $513.78 a month and couples with one aged individ-

[8] In reality, the medically needy are allowed to keep $420 a month for nonmedical expenses, but $20 a month is disregarded in computation of medically needy income levels. The same $20 disregard applies to calculation of SSI benefits.

ual and one disabled individual are eligible for $504.04 a month.

The basic federal SSI payment level is $312.30 a month. In addition, Massachusetts provides a supplemental benefit of $201.48 for an aged couple, and $191.74 for a disabled/aged couple. The disparate impact on the plaintiffs results because of the interplay between the four thirds limit on federal reimbursement for the medically needy and the generous state supplements that Massachusetts provides to SSI recipients.

That impact means that, in order to be eligible for Medicaid, plaintiffs must "spend down" their income [9] on medical expenses to a point where they have only $400 per month available for food, clothing and shelter. To put it another way, Massachusetts allows Social Security recipients in plaintiffs' circumstances $400 a month for nonmedical expenses. If instead the plaintiffs were ineligible for Social Security, or if their Social Security payments were insufficient to put them above the SSI level, they would be automatically eligible for Medicaid as categorically needy SSI recipients. Massachusetts would then allow them $513.78 (or $504.04 in the case of the Hogans) a month for nonmedical living expenses.

As has been pointed out, the Hunters provide a particularly vivid example of this anomaly. Mr. Hunter worked for 41 years in a variety of jobs, and paid Social Security taxes during that period. He and his wife now receive $534.70 in Social Security benefits, or, when reduced by the $20 income

---

[9] The Hogans must spend $246.60 a month, the Bebermans must spend $268.10 a month, and the Hunters must spend $134.70 a month for medical care before receiving any Medicaid benefits.

disregard,[10] $514.70 a month. This is 92 cents higher than the applicable SSI income level of $513.78. And so, if the Hunters' income were literally pennies less, they would be eligible for SSI. As SSI beneficiaries, their medical bills would be fully covered and they would have $100 per month more to spend on basics such as food, clothing and shelter.[11]

An especially bizarre aspect of this anomaly is that individuals with long histories of paying Social Security taxes must live on less than those who have paid little or no tax. If Mr. Hunter, for example, had not worked and paid taxes long enough to become eligible for Social Security payments, he and his wife would have become eligible for SSI, and would have $100 a month more for nonmedical living expenses than they do now.

III. *Discussion*

Citing these apparent parodoxes, the plaintiffs[12] challenge the Massachusetts Medicaid Plan. Seeking declaratory and injunctive relief, they argue that the

---

[10] See note 8 *supra*.

[11] The figures cited in this section reflect the benefit levels and income standards in force at the time of the complaint. On July 1, 1980, the annual cost of living increases went into effect. The discrepancy between medically needy and categorically needy levels is apparently widening the medically needy level is rising at a rate of 6 percent while the categorically needy level is increasing at a 10 percent rate.

[12] In their complaint, plaintiffs seek certification to represent a class including all OASDI recipients who: (a) reside in Massachusetts; (b) are disabled or 65 years of age or over; (c) are ineligible for SSI because of their income; and (d) have medical expenses, not subject to payment by a third party, which exceed the difference between their countable

discrepancy between medically needy and categorically needy income levels violates the Fourteenth Amendment equal protection clause and the equal protection guarantee inherent in the Fifth Amendment due process clause.

Under Fifth [13] and Fourteenth Amendment equal protection analysis, the legislative branch has traditionally enjoyed wide latitude in the areas of economic and social welfare. *See, e.g., Dandridge* v. *Williams*, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970). Some courts have sought to raise the standard of review in public assistance cases.[14] The weight of authority, however, requires that welfare classifications, in the absence of a suspect classification or the infringement of a fundamental right, meet only a minimum rationality test.

---

incomes and the applicable SSI income standard. Complaint, 10(a). Whether or not plaintiffs still purport to represent a class is unclear; this court will assume that they do not. The declaratory relief granted here, however, will necessarily extend to all of the would be class members.

[13] The Fifth Amendment due process clause is now interpreted to encompass traditional Fourteenth Amendment equal protection principles. *See, e. g., Mathews* v. *deCastro*, 429 U.S. 181, 182 n.1, 97 S.Ct. 431, 432, 50 L.E.2d 389 (1976); *Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 638 n. 2, 95 S.Ct. 1225, 1228, 43 L.Ed.2d 514 (1975).

[14] The Third Circuit has argued that the right to welfare benefits is "important" even if not fundamental, *see Medora* v. *Colautti*, 602 F.2d 1149, 1154 (3d Cir. 1979), and that the aged and disabled constitute a "sensitive but nonsuspect class" deserving heightened judicial protection. *See id.* at 1154 55 n. 12.

It has also been noted that welfare classifications involve benefits that make up the sole source of support for many in our society. *See Morales* v. *Minter*, 393 F.Supp. 88, 97 (D. Mass. 1975).

See, e.g., Weinberger v. *Salfi*, 422 U.S. 749, 768-70, 95 S.Ct. 2457, 2468-69, 45 L.Ed.2d 522 (1975); *Hagans* v. *Lavine*, 415 U.S. 528, 529, 94 S.Ct. 1372, 1375, 39 L.Ed.2d 577 (1974); *Dandridge* v. *Williams*, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970). Hence, equal protection does not demand that classifications be made with "mathematical nicety." *Dandridge* v. *Williams*, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970). What it does require is that "the goals sought [be] legitimate, and the classification adopted [be] rationally related to the achievement of those goals." *Richardson* v. *Belcher*, 404 U.S. 78, 84, 92 S.Ct. 254, 258, 30 L.Ed.2d 231 (1971).

Defendants, focusing on the legislative history behind the four-thirds limit on federal reimbursement, cite two main legislative goals justifying the classification at issue here: (1) saving federal money, and (2) assuring that assistance to the medically needy would not supplant private health insurance or Medicare.

The goal of saving tax dollars is certainly noble. But the assertion of that goal as a legitimate basis for disparate treatment invites careful examination. The government can always seek to justify disparate treatment by pointing out the benefits to the public in terms of cost savings. In one sense such a defense would never fail, because it always saves money to deny benefits to a disfavored group. *See Morales* v. *Minter*, 393 F.Supp. 88, 100 (D.Mass. 1975); *Doe* v. *Plyler*, 628 F.2d 448 (5th Cir. 1980). But the standard of minimum rationality, if it is to mean anything at all, must be cloaked with a fabric of at least some substance. Equal protection demands that even limited financial resources be rationally allocated so

that needy individuals in like circumstances are treated with parity.

Measured against this standard, the statutory scheme falls short of the constitutional requirement that it have a rational basis. By definition, medically needy persons and categorically needy persons differ only in the amount of their respective incomes. It would be rational, therefore, to require the medically needy to spend down their income on medical expenses to the SSI basic need level before becoming eligible for Medicaid benefits. That approach would provide Medicaid assistance to all needy people having a certain basic level of income support for non-medical living expenses. There would be no advantaged or disadvantaged class of Medicaid beneficiary.

The Massachusetts Medicaid program, however, does not operate in this manner. Medically needy individuals must spend down until their income reaches an arbitrary point wholly unrelated to the SSI standards of basic need eligibility. In practical terms, this means that, in order to obtain Medicaid benefits, Social Security recipients must do with less food, clothing and shelter than their SSI counterparts.

Defendants argue that the medically needy are by definition wealthier than the categorically needy, and that it is rational, therefore, to favor the categorically needy in allocating Medicaid funds. But this argument ignores reality by looking to plaintiffs' gross income rather than the number of dollars they have available to feed themselves after medical expenses. The plaintiffs here are medically needy persons whose necessary and unreimbursed medical expenses exceed the difference between their incomes and the SSI basic need eligibility level. In reality,

the income available to them for basic nonmedical needs is their gross income minus their medical expenses. In each of their cases, the money they have left after medical expenses is substantially below the basic need standard recognized by SSI. It is hardly rational for the defendants to rely on the fact that, if the plaintiffs were healthy, they would have greater income than SSI recipients. If plaintiffs were healthy they would not be seeking relief from this court.

Defendants also contend that, even if the statutory scheme creates some inequities, Congress rationally accepted these inequities as the price to be paid for conserving fiscal resources. This argument raises an important issue. Did Congress balance opposing considerations and then knowingly and rationally create the classification complained of here? The resolution of this issue requires an examination of the legislative history behind the four-thirds rule.

When Congress enacted the Medicaid program in 1965, it clearly meant to prohibit the states from forcing anyone to spend down below categorically needy income standards:

> In no event, however, . . . may a State require the use of income and resources which would bring the individual's income below the amount established as a test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

[1965] *U.S.Code Cong. & Ad.News*, pp. 1943, 2019 (reprinting *S.Rep.No.* 404, 89th Cong., 1st Sess. (1965)).

In 1967, Congress, concerned about rising federal costs, amended the 1965 provisions by imposing the four-thirds limit. The defendants perceive in the 1967 amendments a change in Congressional intent, a willingness to create some inequity in order to hold down costs. The legislative history, however, does not bear this out.

Congressional consideration of the four-thirds rule was minimal. The amendment was but one small part of a Social Security bill containing wide-ranging revisions in several programs. The bill itself was pushed through both houses quickly, and legislators deplored the inadequate opportunity for study and debate.[15] Moreover, given the clear intent in 1965 to treat the medically needy and categorically needy equally, one would expect some affirmative indications of the supposed Congressional change of heart. In fact, the record is eloquently silent.[16]

---

[15] *See* 113 *Cong. Rec.* 23129 (1967) (remarks of Rep. Mathias) ("The House has had less than two weeks to consider the committee's proposals, and in this short time has not been able to make a full assessment of their impact nationally or in individual cites and states."); *id.* at 36783-84 (1967) (complaint of Sen. Robert Kennedy that there had been little time to consider Conference bill).

[16] The evidence of intent relied on by defendants is either out of context or totally inapposite. For example, the federal defendant cites the testimony of Wilbur J. Cohen, Undersecretary of HEW, before the Senate Finance Committee. Undersecretary Cohen did point out that the four-thirds rule would in some states force a spend-down below the cash assistance level. *See Social Security Amendments of 1967: Hearings Before the Senate Finance Committee*, 90th Cong., 1st Sess. 280 (1967). But he was not testifying about the medically needy-categorically needy discrepancy. The Undersecretary's complaint was that the four-thirds rule would,

On the other hand, there are affirmative indications that Congress was not even aware of the disparate treatment which the four-thirds rule was likely to create. First, the conditions which led Congress to restrain federal expenditures for the medically needy in 1967 were entirely different from those now prevailing in Massachusetts. Congressional debate focused on the medically needy standards then in effect in New York, which made 45 percent of the entire state population eligible for Medicaid.[17] *See, e.g.*, 113 *Cong. Rec.* 22783 (1967) (remarks of Rep. Bingham); *id.* at 23104, 23108-09, 23087, 23093, 23098-99 (1967) (remarks of Reps. Bingham, Reid, Kupferman, Halpern, and Ryan); *id.* at 33168, 33171 72 (1967) (remarks of Sens. Javits and Robert Kennedy). The four-thirds rule was a reaction against state eligibility standards in the middle income range. See *id.* at 23099 (remarks of Rep. Ryan) ("The controversial point here is, of course, that some persons are included in the New York plan who are not related to traditional concepts of welfare cases.")

By tightening the reins on the overly generous spending of some states, Congress sought to prevent the medically needy program from becoming a na-

---

due to the vagaries of state AFDC programs, exclude some of the categorically needy from Medicaid coverage. *See id.* Similarly, defendants quote Senator Long's remark that the categorically needy have "first call on Federal funds." 113 *Cong.Rec.* 32594 (1967). But the Senator's observation related to a proposed reduction in the rate of federal reimbursement, a provision which the Conference Committee later eliminated from the bill.

[17] *See* R. Stevens and R. Stevens, Welfare Medicine in America 92 (1974).

tional health insurance program for the middle class. *See H.R.Rep.No.*544, 90th Cong., 1st Sess. 118 (1967) ("Your committee neither expected or intended that such care would supplant health insurance presently carried or presently provided under collective bargaining agreements for individuals in or close to an average income range.") Hence, Congressional attention was directed toward the eligibility of the middle class for medically needy funds, a topic far afield from the plight of lower income Social Security recipients such as the plaintiffs here.

Second, the discrimination at issue here resulted from an eleventh hour revision of the 1967 amendments, designed to attack a particular anomaly in the categorically needy provisions. The original versions of the bill all contemplated a single spending limit applicable to both the categorically and the medically needy.[18] But testimony before the Senate Finance Committee revealed that the House version of the bill would deprive some of the categorically needy of any Medicaid benefits. *See Social Security Amendments of 1967: Hearings Before the Senate Finance Committee*, 90th Cong., 1st Sess. 280 (1967). The problem was that the House version set a maximum income level, for both the categorically and medically needy, of four thirds the amount actually paid out by the states under AFDC. Since some states paid out less than 75 percent of the cash assistance level,

---

[18] The Administration version called for a limit of 150 percent of the state's highest categorical income standard. *See* 113 *Cong.Rec.* 3899 (1967). The bill reported by the House contained a limit of four-thirds the AFDC standard. *See id.* at 21267, 23132. The Senate preferred a limit of 150 percent of the Old Age Assistance Standard. See *id.* at 32450, 33637.

the inevitable result was that some persons eligible for cash assistance would be ineligible for Medicaid.[19]

Confronted with this difficult problem, the Conference Committee adopted a simple solution. It exempted the categorically needy from the four-thirds limits. *See* [1967] *U.S.Code Cong. & Ad.News*, pp. 3179, 3209 (reprinting *Conf.Comm.Rep.No.* 1030, 90th Cong., 1st Sess. (1967)). As a result, all of the categorically needy would be entitled to Medicaid, regardless of the individual state's AFDC payment standards. The House enacted the Conference version two days after it was reported. *See* 113 *Cong. Rec.* 35918, 36393 (1967). Two days after the House action, the Senate followed suit. *See id.* at 36924.

In short, the 1967 amendments provided, throughout their passage in the House and Senate, for equal treatment of the categorically and medically needy. It was not until the bill reached the Conference Committee that the changes occurred that eventually triggered this law suit. And of great significance in fathoming Congressional intent is the fact that this eleventh hour change did not grow out of any reconsideration of the relative need of the categorically and medically needy. It would be an exercise of

---

[19] Undersecretary of HEW Wilbur J. Cohen provided the following example:

> [I]n Indiana, a family of four is eligible to receive assistance if their income is less than $271.40 a month, yet the highest amount that can be paid in assistance is $103. The House bill would mean that for the purpose of Federal matching, the family could receive cash assistance if their monthly income is up to $271.40, but medical assistance only if their income is below $137, about half of the eligibility level for cash payments.

Social Security Amendments of 1967: Hearings Before the Senate Finance Committee, 90th Cong., 1st Sess. 280 (1967).

fiction, not statutory construction, to charge Congress with having even discovered, let alone approved, the harmful consequences now apparent, given the short time for debate following the Conference Committee report.

Third, members of Congress who registered concern as to other provisions thought to discriminate against the medically needy did not oppose the four-thirds rule and its exemption for the categorically needy. The version of the Medicaid amendments favored by the Senate Finance Committee called for a reduction in the rate of federal reimbursement of medically needy programs. Senator Javits objected to the bill on the ground that it discriminated against the medically needy:

> The essence of our argument is that there is discrimination. The State is induced not to extend medical assistance because they are not drawing cash relief. . . . Senator Long wants to encourage people to go on cash relief. *Do not discriminate against them; lower your income eligibility limit, if you want; but treat everybody who falls below the ceiling in the same manner. That is the essence of our argument.*

113 *Cong.Rec.* 33171 (1967) (emphasis supplied).

Senator Javits' position ultimately carried the day. The final version of the amendments eliminated the reduction is reimbursement rate. Yet when the philosophically indistinguishable four-thirds rule came up for debate, no Congressional concern was expressed. It is significant that even Senator Javits, who had been an outspoken advocate, neither objected to the rule nor voiced any change of heart on the issue of parity for the medically needy. The only rational explanation as to why this legislative dis-

parity exists is that the Congress, in its eleventh hour consideration of the issue, did not recognize the full implications of the four-thirds rule. If Congress had foreseen the anomaly complained of here, surely the record would reflect some discussion paralleling the earlier debates over the proposed reduction in reimbursement rate.

Fourth, when Congress intended to alter statutory "comparability" requirements, it clearly expressed that intent. Under 42 U.S.C. § 1396a(a)(10)(c), medically needy income standards must be "comparable" to categorically needy standards, and medical services provided to each group within the medically needy class must be "equal in amount, duration, and scope" to services provided the other groups.

In 1967, Congress decided to modify the latter "comparability" requirement in an effort to coordinate Medicaid with the Medicare program. This change appeared as section 223(a) of the 1967 amendments under the heading "Modification of Comparability Provisions." *See* Pub.L.No. 90-248, § 223(a), *reprinted in* [1967] *U.S.Code Cong. & Ad.News* at 1024. But there was no mention under that same heading of any change in the first "comparability" requirement, even though the same amendments contained the four-thirds rule. Had Congress realized that the four-thirds rule would create a substantial disparity between medically needy and categorically needy income standards, it most likely would have denominated the rule a "modification of comparability provisions" as well.

Fathoming Congressional intent can be a challenging exercise. Fictionalizing such intent is much easier. This court chooses to resist the multiple temptations inherent in the latter course. Here, the legis-

lative history demonstrates that Congress never considered, let alone intended, the eventual effects of the four-thirds rule. It paints the picture of a Congress, anxious to remedy one form of discrimination in a complex legislative scheme, inadvertently creating another kind of discrimination by making a last-minute revision. That is not a criticism. It is simply an emphathetic statement of fact.

Congress did not rationalize the disparate treatment suffered by the plaintiffs here as being an inevitable, but legitimate, result of resource rationing and allocation. To the contrary, the Congress did not even foresee the disparity demonstrated by the circumstances of this case. The plight of the plaintiffs here is the result of a legislative accident. Under such circumstances, invalidation does not amount to a second guessing of Congressional policymaking. *See Delaware Tribal Business Commission* v. *Weeks*, 430 U.S. 73, 97-98, 97 S.Ct. 911, 925-926, 51 L.Ed.2d 173 (1976) (Stevens, J., dissenting).

Defendants, however, assert a second purpose behind the statutory scheme, namely, to assure that the medically needy program would not supplant Medicare or private health insurance. The legislative history, however, contains no evidence that Congress viewed the four-thirds rule as a means of coordinating Medicare and Medicaid coverage. Defendants point to language apparently to the contrary,[20] but

---

[20] "Your committee is also concerned that the operation of some State plans may greatly reduce the incentives for persons aged 65 or over to participate in the supplementary medical insurance program of Title XVIII of the Social Security Act, which was also established by the Social Security Amendments of 1965." *H.Rep.No.*544, 90th Cong., 1st Sess. 118 (1967).

these quotes in fact refer to certain "buy-in" provisions entirely unrelated to the four-thirds rule.

Congress did hope that the rule would prevent duplication of private health insurance. But the targets of Congressional concern clearly were middle income families and individuals, not aged and disabled Social Security recipients. *See H.Rep.No.*544, 90th Cong., 1st Sess. 118 (1967). Indeed, Congress had before it evidence as to the inadequacy of private insurance available to the aged. *See Medical Care for the Aged: Hearings Before the House Ways and Means Committee*, 89th Cong., 1st Sess. 40-44 (1965). The expressed purpose to prevent duplication of middle income families' private health insurance, however, cannot support a rule which cuts so deeply into the basic needs of some of society's poorest individuals. A limit of four-thirds the AFDC level bears no rational relation to the earning level of middle income people.

IV. *Conclusion*

Finding no rational basis for the distinction drawn between Social Security and Supplemental Security Income recipients, this court holds the Massachusetts Medicaid program unconstitutional insofar as it forces Social Security recipients to spend down below Supplemental Security Income levels before receiving medical benefits. Plaintiffs' motion for partial summary judgment is allowed, and defendants' motion for partial summary judgment is denied.

APPENDIX B

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CA 80-883-T

GEORGE HOGAN, ET AL., PLAINTIFF

v.

PATRICIA HARRIS, ET AL., DEFENDANTS

ORDER

November 21, 1980

TAURO, D.J.

For the reasons stated in the opinion issued this date, plaintiffs' motion for partial summary judgment is allowed and defendants' motions for partial summary judgment are denied. The parties are instructed to appear for a conference at a date and time to be arranged by the Clerk, to discuss the issue of appropriate relief in this case.

/s/ J. H. Tauro
J. H. TAURO
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CA 80-883-T

GEORGE HOGAN, ET AL., PLAINTIFFS

v.

PATRICIA HARRIS, ET AL., DEFENDANTS

ORDER

December 22, 1980

TAURO, D.J.

The court wishes to clarify a point upon which some confusion developed during the December 19 conference. The November 21 opinion and order in this case held the Massachusetts Medicaid program unconstitutional. That program, of course, contains federal and state components. It is the confluence of federal and state requirements which renders the Massachusetts program unconstitutional. It is that federal-state program which this court held to be unconstitutional, and not merely the Massachusetts medicaid statute.

By the Court:

GEORGE F. MCGRATH
Clerk

/s/ Emma M. Hayes
EMMA M. HAYES
Deputy Clerk

J. H. TAURO
United States District Judge

APPENDIX D

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil No. 80-883

GEORGE HOGAN, ET AL., PLAINTIFFS

v.

RICHARD SCHWEIKER, ET AL., DEFENDANTS

ORDER

On the basis of the uncontradicted affidavits submitted by the Plaintiffs, the Court finds that the named Plaintiffs are members of a class so numerous that joinder of all members is impractical; that the issues raised by Counts I and II of the Complaint and the Plaintiffs' and Defendants' Motions for Summary Judgment are common to all class members; that the claims of the named Plaintiffs are typical of the claims of the class; that the named Plaintiffs will fairly and adequately represent the class; and that the Plaintiffs seek declaratory and injunctive relief against actions by the Defendants on grounds generally applicable to the class.

Accordingly, it is ORDERED that so much of the action as concerns the claims of Counts I and II of the Complaint and the Plaintiffs' and Defendants' Motions for Summary Judgment be certified under Rule 23(b)(2) as a class action on behalf of the class consisting of all (i) present and future Social Security recipients; (ii) who reside or will reside in Massachusetts; (iii) who are or will be disabled or 65 years old or older; (iv) who are or will be in-

eligible because of the amount of their incomes for Massachusetts Supplemental Security Income payments; and (v) who have or will have, as determined in accordance with the applicable Massachusetts Medicaid regulations, medical expenses not subject to payment by a third party which exceed the difference between their countable incomes under the Massachusetts Medicaid regulations and the applicable Massachusetts Supplemental Security Income standard.

3/30/81

/s/ J. H. Tauro
United States District Judge

APPENDIX E

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CA 80-883-T

GEORGE HOGAN, ET AL., PLAINTIFFS

v.

RICHARD SCHWEIKER, ET AL., DEFENDANTS

ORDER

April 9, 1981

TAURO, D.J.

1. Pursuant to Rule of Civil Procedure 54(b), the court determines that, although the claims raised by Count III of the Complaint remain to be adjudicated, there is no just reason for delay in entering judgment on Counts I and II and directs that final judgment be entered for the plaintiff class on Counts I and II of the Complaint and in accordance with the court's orders of November 21, 1980, and December 22, 1980.

2. By way of further clarification of its Orders of November 21 and December 22, 1980, the court states that its ruling holds unconstitutional, in addition to the Massachusetts Medicaid income eligibility standards applied to the plaintiff class, the federal statute limiting Medicaid reimbursement, 42 U.S.C. section 1396b(f).

/s/ J. H. Tauro
United States District Judge

APPENDIX F

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No. 80-833-T

GEORGE HOGAN, ET AL., PLAINTIFFS

v.

PATRICIA HARRIS, ET AL., DEFENDANTS

[Filed December 22, 1980]

NOTICE OF APPEAL TO SUPREME COURT OF THE UNITED STATES

Notice is hereby given this 22d day of December, 1980, that defendant Patricia Harris, Secretary, Department of Health and Human Services, hereby appeals to the Supreme Court of the United States from the Opinion and Order of this Court entered on 21st day of November, 1980. This appeal is taken pursuant to Title 28, United States Code, Section 1252.

By her attorney,

EDWARD F. HARRINGTON
United States Attorney

by: /s/ Nelson G. Dong
NELSON G. DONG
Assistant U.S. Attorney

CERTIFICATE OF SERVICE

I, Donald R. Anderson, certify that on December 22, 1980, a copy of this notice was mailed to William H. Simon, Esquire, Legal Services Institute, 3529 Washington Street, Jamaica Plain, Massachusetts, and to Thomas Miller, Assistant Attorney General, Room 2019, One Ashburton Place, Boston, Massachusetts 02108.

/s/ Donald R. Anderson
DONALD R. ANDERSON
Assistant U.S. Attorney

APPENDIX G

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No. 80-833-T

GEORGE HOGAN, ET AL., PLAINTIFFS
v.
RICHARD SCHWEIKER, ET AL., DEFENDANTS

[Filed April 22, 1981]

NOTICE OF APPEAL TO SUPREME COURT
OF THE UNITED STATES

Notice is hereby given this 22nd day of April, 1981, that Defendant Richard Schweiker, Secretary, Department of Health and Human Services, hereby appeals to the Supreme Court of the United States from the Order of this Court entered on 9th day of April, 1981, "by way of further clarification of its Orders of November 21 and December 22, 1980." This appeal is taken pursuant to Title 28, United States Code, Section 1252.

By his attorney,

EDWARD F. HARRINGTON
United States Attorney

by: /s/ Nelson G. Dong
NELSON G. DONG
Assistant U.S. Attorney

CERTIFICATE OF SERVICE

I, Donald R. Anderson, certify that on April 22, 1981, a copy of this notice was mailed to William H. Simon, Esquire, Legal Services Institute, 3529 Washington Street, Jamaica Plain, Massachusetts, and to Thomas Miller, Assistant Attorney General, Room 2019, One Ashburton Place, Boston, Massachusetts 02108.

/s/ Donald R. Anderson
DONALD R. ANDERSON
Assistant U.S. Attorney

APPENDIX H

STATUTORY PROVISIONS INVOLVED

Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f), is as follows:

> Limitation on Federal participation in medical assistance
>
> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under Part A of subchapter IV of this chapter.
>
> (ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.
>
> (C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe.

be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family without any income or resources) consisting of one person if such plan (without regard to section 608 of this title) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

> (A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(B) who is not receiving such aid or assistance and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

at the time of the provision of the medical assistance giving rise to such expenditure.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1981 350118 526

Joint Appendix

Office - Supreme Court, U.S.
FILED
NOV 25 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-213

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,
Appellant

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

JOINT APPENDIX

Jurisdictional Statement filed July 31, 1981
Probable Jurisdiction Noted Oct. 13, 1981

In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-213

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,
Appellant

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

INDEX

	Page
Relevant Docket Entries	1
Complaint (Apr. 29, 1980)	7
Affidavit of George Hogan (May 20, 1980)	33
Affidavit of George Hunter (May 20, 1980)	37
Statement of Material Facts Not in Dispute (July 3, 1980)	42
Plaintiffs' Motion for Summary Judgment (July 25, 1980)	44
Order Noting Probable Jurisdiction (Oct. 13, 1981)	45

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

GEORGE HOGAN, PEARL HOGAN, CELIA BEBERMAN, HENRY BEBERMAN, GEORGE HUNTER, and CECILIA HUNTER, on behalf of themselves and all others similarly situated, PLAINTIFFS

v.

PATRICIA HARRIS, United States Secretary of Health and Human Services; CHARLES MAHONEY, Secretary of Human Services of the Commonwealth of Massachusetts; and JOHN PRATT, Commissioner of the Department of Public Welfare of the Commonwealth of Massachusetts, DEFENDANTS

Cause: Civil Rights

DOCKET ENTRIES

DATE	NR.	PROCEEDINGS
1980		
Apr. 29	01	Complaint filed.
Apr 30	02	*ALEXANDER, USM* Mtns of P. Hogan, G. Hogan, H. Beberman, C. Beberman, C. Hunter, and G. Hunter to proceed in forma pauperis ALLOWED.
May 20	05	Ps' mtn for preliminary injunction, filed, c/s.
May 20	06	Ps' memo in support of #05, filed, c/s.
May 20	07	Affid of George C. Hunter, filed, c/s.
May 20	08	Affid of Celia Beaverman, filed, c/s.
May 20	09	Affid of John Polk, M.D., filed c/s.
May 20	10	Affid of George Hogan in support of #05, filed, c/s.

DATE	NR.	PROCEEDINGS
1980		
May 20	12	Affid of Joanne Doyle, filed, c/s.
May 21		HEARING ON #05 SCHEDULED FOR 6/9/80 at 11:15 AM; notation on #11.
June 5		HEARING ON #05 CONT'D TO 6/16/80, 2:15 PM; Atty. Simon to notify AG Miller in writing; counsel notified today by phone.
June 13	15	Ds' memo in oppos to #05, filed, ref. to TAURO, DJ.
June 16	16	Ps' reply to Mass. Ds' memo in oppos to #05, filed, ref. to TAURO, DJ.
June 16		*TAURO, DJ.* Hearing on motion #5; argument; any further memoranda to be filed (with respect to legislative history) within 2 weeks. Matter to be then taken under advisement.
June 30	17	D's mtn to extend time for filing statement of legislative history, to 7/2/80, filed, indicating Ps do not object, filed, c/s, ref. to TAURO, DJ.
July 3	18	Statement of material facts not in dispute, filed by Ds, c/s.
July 3	19	Federal Ds' mtn for partial summary judgment, filed, c/s.
July 3	20	Ds' memo of points and authorities in support of #19, filed, c/s. Ref. to TAURO, DJ, #18 thru 20.
July 11	21	Ps' oppos to Federal D's mtn for summary judgment, and mtn for addit'l time to file memo in support of oppos, to 7/17/80, filed, ref. to TAURO, DJ.
July 21	25	Answer of Ds Charles Mahoney and John Pratt, filed, c/s.
July 25	26	Ps' mtn for partial summary judgment, filed, w/draft order, c/s.

DATE	NR.	PROCEEDINGS

1980

July 25 27 Ps' memo in oppos to #19 and in support of #05 and #26, filed c/s. Ref. to TAURO, #25, 26, 27.

July 25 28 Letter to Clerk from William H. Simon, dated 7/25/80, re #26, 27, and summary disposition of Counts I and II of complaint, and request for speedy ruling re #05; filed, ref. to TAURO, DJ.

Aug 4 29 Ps' application for default of Ds Mahoney and Pratt, filed, c/s.

Aug 5 30 State Ds' mtn to extend time for filing oppos to Ps' mtn for partial summ judgment, to 8/14/80, filed, c/s, ref. to TAURO, DJ.

Aug 11 *TAURO, DJ* (By the Court) #30 ALLOWED; cc/cl.

Aug 11 Confirmed w/Atty. Simon that Ds Mahoney & Pratt have answered; no action necessary on #29.

Sept 4 36 State Ds' mtn for partial summary judgment, filed, c/s, draft order attached.

Sept 4 37 Memo of Ds Mahoney and Pratt in oppos to Ps' mtn for partial summ judgment and in support of #36, filed c/s. Ref. to TAURO, DJ, #36, 37.

Sept 9 38 Federal defts opp to Ps motion for partial SJ, filed cs. Referred to TAURO, DJ

Sept 12 39 Ps reply memo to #38, filed cs.

Nov 21 *TAURO, DJ* ORDER ENTERED: "For the reasons state in the opinion issued this date, Ps.' motion for partial summary judgment is ALLOWED and Ds.' motion for partial summary judgment is DENIED. The parties are instructed to appear for a conference at a date and time to be arranged by the Clerk, to discuss the issue of appropriate relief in this case." Filed, cc/cl.

DATE	NR.	PROCEEDINGS
1980		
		TAURO, DJ OPINION ISSUED, filed, cc/cl.
Nov 26	40	Ps' mtn for certification of Plaintiff class, filed, c/s.
Nov 26	41	Ps' memo in support of #40, filed, c/s.
Nov 26	42	Affid of William H. Simon, filed, c/s.
Dec 22		*TAURO, DJ* ORDER ENTERED: (to clarify a point on which confusion developed during 12/19/80 conference)" . . . It is the confluence of federal and state requirements which renders the Mass. program unconstitutional. It is that federal-state program which this court held to be unconstitutional, and not merely the Mass. medicaid statute." Filed, cc/cl.
Dec 19		Proposed order of Ps w/respect to class, and proposed order w/respect to named Ps, submitted.
Dec 19		TAURO, DJ. Conference held:
Dec 22		Deft. Patricia Harris, Secretary, Department of Health and Human Services, Notice of Appeal to Supreme Court Of The United States filed. c/s
1981		
Jan 13		Certified copy of docket entries and original pleadings forwarded to the United States Supreme Court, Washington, D.C.
Jan 19		Acknowledgement of copy of letter to United States Supreme Court dated 1/13/81 that original pleadings had been received.
Jan 30	44	Steno transcript of proceedings of 12/19/80, filed.
Feb 5	45	Letter to Clerk from Thomas Miller, same date, advising Ds Mahoney and Hogan to not oppose Ps' application for class certification; filed, ref. to TAURO, DJ Atty. Maclay will forward satement of non-opposition of Federal Ds to Ps' mtn for class certification.

DATE	NR.	PROCEEDINGS

1981

Mar 30 47 *TAURO, DJ* ORDER ENTERED: ". . . the Court finds that the named Plaintiffs are members of a class so numerous that joinder of all members is impractical; that the issues raised by Counts I and II of the Complaint and (the parties') Motions for Summary Judgment are common to all class members; that the claims of the named Ps. are typical of the claims of the class; that the named Ps. will fairly . . . represent the class; and that the Ps. seek . . . relief . . . on grounds generally applicable to the class . . . ORDERED that . . . the action as concerns the claims of Counts I and II . . . and (the parties') Motions for Summary Judgment be certified . . . as a class action . . . consisting of all (i) present and future Soc. Sec. recipients; (ii) who reside or will reside in Mass.; (iii) who are or will be disabled or 65 years old or older; (iv) who are or will be ineligible because of the amount of their incomes for Mass. Supplem. Sec. Income . . .; and (v) who have or will have, . . . medical expenses not subject to payment by a third party which exceed the difference between their countable incomes under the Mass. Medicaid regs. and the applicable Mass. Supplem. Sec. Income standard." Filed, cc/cl.

Apr 6 *TAURO, DJ* Hearing re First Circuit's dismissal of appeal; Plaintiffs to file proposed Rule 54(b) certificate within 2 days.

Apr 8 Proposed order for Rule 54(b) certificates submitted by Atty. Simon, ref. to TAURO, DJ.

Apr 8 48 Letter to Clerk from William H. Simon, dated 4/7/81, re proposed order above, stating that it has been read by Mssrs. McClay and Miller, and they have no objections; filed.

April 10 50 Letter to TAURO, DJ, from William H. Simon, dated 1/6/80, renewing Ps' request for action of Ps' mtn to cert class, filed.

DATE	NR.	PROCEEDINGS

1981

April 10 51 Letter to TAURO, DJ, from John B. Maclay, undated, in response to inquiries as to federal Ds' position of mtn for class cert, filed.

April 10 52 Letter to TAURO, DJ, from William H. Simon, dated 2/24/81, informing of recent developments in case making further court action appropriate, requesting opportunity for counsel to discuss issues w/Court, filed.

April 10 53 Letter to TAURO, DJ, from William H. Simon, dated 2/23/81, in response to federal D's oppos to Ps' mtn to cert class, filed.

April 9 54 *TAURO, DJ* ORDER ENTERED: "1. . . . the court determines that . . . there is no just reason for delay in entering judgment on Counts I and II and directs that final judgment be entered for the plaintiff class on Counts I and II of the Complaint and in accordance with the Court's orders of November 21, 1980, and December 2, 1980.

2. By way of further clarification . . . the court states that its ruling holds unconstitutional, in addition to the Mass. Medicaid income eligibility standards applied to the plaintiff class, the federal statute limiting Medicaid reimbursement, 42 U.S.C. section 1396b(f)." Filed, cc/cl.

April 22 55 Federal defts Notice of Appeal to U.S. Supreme Court of the U.S. filed. c/s

April 28 Certified copy of pleadings and docket entries forwarded to the U.S. Supreme Court of the U.S. Washington, D.C.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No. 80-883-T

[Filed Apr. 29, 1980]

GEORGE HOGAN, PEARL HOGAN, CELIA BEBERMAN, HENRY BEBERMAN, GEORGE HUNTER, and CECILIA HUNTER, on behalf of themselves and all others similarly situated, PLAINTIFFS

v.

PATRICIA HARRIS, United States Secretary of Health and Human Services; CHARLES MAHONEY, Secretary of Human Services of the Commonwealth of Massachusetts; and JOHN PRATT, Commissioner of the Department of Public Welfare of the Commonwealth of Massachusetts, DEFENDANTS

COMPLAINT

I. INTRODUCTION

1. This is an action to enjoin the termination or withholding of Medical Assistance benefits desperately needed by the named Plaintiffs and the class of elderly and disabled individuals they represent. On behalf of themselves and similarly situated individuals, the Plaintiffs seek declaratory and injunctive relief against two practices of the Massachusetts Medical Assistance ("Medicaid") Program which deprive them [of] benefits to which they are entitled under Title XIX of the Social Security Act, 42 U.S.C. 1396a, et seq., and the guarantees of Equal Protection of the Fifth and Fourteenth Amendments to the United States Constitution.

2. Counts I and II seek relief on constitutional grounds from the practice of discriminating against Medicaid applicants who live on Social Security retirement or

disability insurance by allowing them for their non-medical needs substantially less than the amount Massachusetts has determined as sufficient for such needs and which it allows to a class of identically situated aged and disabled Medicaid recipients who are also beneficiaries of Supplemental Security Income (SSI) Payments.

3. Count III seeks relief from the practice of refusing to provide assistance to individuals who can become eligible for Medicaid payments by applying a portion of their own incomes to their medical expenses until such individuals have incurred medical expenses in an amount six times the applicable monthly portion of their incomes.

4. The named Plaintiffs are three elderly couples living on Social Security. One member of each couple suffers from severe medical impairments and can live outside an institution only with extensive medical services and treatment, in the case of two of them, at a cost above $1100 per month. None of them is able to pay for the cost of medical treatment. If the Plaintiffs were SSI recipients they would receive a monthly cash grant for their non-medical needs and full Medicaid coverage. However, because they live on Social Security, Massachusetts has refused to provide them with Medicaid until they incur on their own medical expenses ranging from $450 to about $1500, in the case of two couples, more than twice their total monthly incomes. To do so would reduce their incomes far below the amount Massachusetts provides SSI recipients and would leave them unable to provide for their non-medical needs. Without the level of Medicaid coverage provided SSI recipients, the Plaintiffs face potentially fatal illness or institutionalization.

II. JURISDICTION

5. This suit is authorized by 42 U.S.C. § 1983, and by 28 U.S.C. §§ 2201, 2202. The amount in controversy exceeds $10,000. Jurisdiction is conferred by 28 U.S.C.

§§ 1331, 1343, 1361, and by the Fifth and Fourteenth Amendments to the United States Constitution.

III. PARTIES

6. The plaintiffs George Hogan, Pearl Hogan, Celia Beaverman, Henry Beaverman, George Hunter and Cecilia Hunter are residents of Massachusetts.

7. The defendant Patricia Harris is Secretary of the United States Department of Health and Human Services ("the Secretary"). She is the federal cabinet official responsible for the administration and enforcement of Titles II, XVI, and XIX of the Social Security Act, which provide respectivley for the Old Age, Survivors, and Disability Insurance program ("OASDI"), the Supplemental Security Income program ("SSI") and the Medicaid program.

8. The defendant Charles Mahoney is Secretary of Human Services of the Commonwealth of Massachusetts. He is the state cabinet official responsible under G.L. c.6A §§ 4, 16, for the administration for the Massachusetts Medicaid program.

9. The Defendant John Pratt is Commissioner of the Massachusetts Department of Public Welfare, ("the Department"), which administers the Massachusetts Medicaid Program pursuant to G.L. c. 118E § 4. He is responsible under G.L. c.18 § 3, for the direction, supervision and control of the Department.

IV. CLASS ACTION

10. The named plaintiffs bring this action on behalf of themselves and, pursuant to Federal Rule of Civil Procedure 23(a) and (b)(2), on behalf of all others similarly situated. The classes the plaintiffs represent are as follows:

(a) In Counts I and II, plaintiffs represent all (i) Social Security (OASDI) recipients; (ii) who reside in Massachusetts; (iii) who are disabled or 65 years old

or over; (iv) who are ineligible because of the amount of their incomes for SSI payments; and (v) who have medical expenses not subject to payment by a third party greater than the difference between their countable incomes (as determined in accordance with the Massachusetts "medically needy" income regulations) and the amount of the SSI income standard applicable to them.

(b) In Count III, the plaintiffs represent all persons eligible for surplus ("spend-down") coverage under the Massachusetts Medicaid program who have regularly recurring monthly medical expenses in an amount greater than the amount by which their monthly countable incomes exceed the applicable Medicaid monthly income standard.

11. Each class is so numerous that joinder of all members is impracticable. There are common questions of law and fact. The plaintiffs' claims are typical of the claims of all members of the classes. Defendants have acted and continue to act on grounds generally applicable to all class members, thereby making declaratory and injunctive relief appropriate with respect to each class as a whole.

V. STATUTORY AND REGULATORY FRAMEWORK

A. INCOME STANDARDS

12. OASDI is the basic Social Security program designed to protect the aged and disabled against economic insecurity. In order to receive OASDI benefits a wage earner must attain age 65 (or for reduced benefits, age 62), 42 U.S.C. § 402(a), (q)(1) and (9), or become disabled within the meaning of the statute. 42 U.S.C §§ 416 (i), 423 (d)(1)(A). Benefits are financed from taxes levied on workers and their employers, and eligibility also depends on having engaged in a requisite amount of employment covered by the tax.

13. SSI is the federal cash assistance program for the aged and disabled. The eligibility criterion of age is

also 65 years old, and the criterion of disability is identical to the disability criterion for OASDI benefits under Title II of the Social Security Act. 42 U.S.C. § 1382c (a) (1) and (3). SSI payments are not based on the recipient's work history or on taxes paid by recipients. SSI eligibility depends on a showing that the applicant's income (less certain exemptions and disregards) is below the applicable SSI income standard. Minimum income standards are established by Congress, but these levels may be raised by supplemental payments made by the State. Massachusetts has chosen to supplement the basic federal standards by amounts based on a determination of the Department of Public Welfare of the needs of the aged and disabled. Mass. G.L. c.118D § 2. The Massachusetts SSI income eligibility standards as in effect from July 2, 1978 to June 30, 1979 are set forth on Exhibit A hereto; the standards in effect since July 1, 1979 are set forth in Exhibit B hereto. Exhibits A and B are incorporated herein by reference.

14. Medical Assistance ("Medicaid") is a cooperative federal-state program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., which pays for the cost of medical treatment for certain categories of people whose income is insufficient to meet their needs. Medicaid benefits are provided in accordance with plans formulated by the states subject to the requirements of the Act and of regulations promulgated by the Secretary. The states are reimbursed by the federal government for a portion of the expenses of these plans in accordance with a statutory formula. 42 U.S.C. § 1396b.

15. Pursuant to 42 U.S.C. § 1396a (a) (10), Massachusetts provides Medicaid both to the aged and disabled "categorically need", which include those who are eligible for SSI, and to the aged and disabled "medically needy", which include those who are not eligible for SSI because of their income but "who have insufficient . . . income and resources to meet the costs of necessary medical and remedial care and services." The purpose of

the medically needy program is to assist people who have income too high to qualify for cash assistance but whose income, when reduced by their medical expenses, is insufficient to take care of their basic needs.

16. In terms of the goals of the Medicaid program, each member of the Plaintiff class is identically situated to each member of the class of aged and disabled SSI recipients. All meet the same criteria of age or disability, and all, when their medical expenses are accounted for, have income less than the amount which the Department has determined to be minimally sufficient for the needs of the aged and disabled in the SSI program under G.L. c.118 § 2. Yet the Department provides assistance to the Plaintiff class in accordance with standards less favorable than those it applies to aged and disabled SSI recipients. SSI recipients receive a cash grant for their non-medical needs and full Medicaid coverage. The aged and disabled medically needy are eligible for Medicaid coverage once they have incurred medical expenses which reduce their income to the medically needy income standard. The Massachusetts medically needy income standards in effect from December, 1977 to December, 1979 are attached hereto as Exhibit C; the standards in effect since December, 1979 are attached hereto as Exhibit D. Exhibits C and D are incorporated herein by reference. In the language of the program, the medically needy must "spend down" to the medically needy income standards. However, because the medically needy standards are less than the SSI grant standards, members of the Plaintiff class are left with less income for non-medical needs than aged and disabled SSI recipients receive for such needs. The extent of the difference varies depending on the marital status and living arrangements of the applicants. For example, an aged SSI couple living alone receives a monthly cash grant which leaves them at least $513.78 for their non-medical needs plus full Medicaid coverage. An aged couple living alone on OASDI income must spend all but $400 of their non-exempt income for medical ex-

penses before they can receive. [*sic*]. This discrimination deprives members of the Plaintiff class of income which the Department itself has determind to be necessary for basic needs of the aged and disabled. Compare Exhibits A and B with Exhibits C and D.

17. Massachusetts' discrimination between the Plaintiff class and aged and disabled SSI recipients parallels the discrimination in Medicaid income limitations set forth in 42 U.S.C § 1396b(f). States cannot receive federal reimbursement for payments made to individuals whose incomes exceed these limitations. For SSI recipients, the maximum income limitation is the same as the SSI income standards. *Id.* at ¶ (4)(A). For the medically needy aged and disabled, the maximum limitation is 133⅓, or four-thirds, of the income standards used in the state's Aid to Families with Dependent Children (AFDC) program. *Id.* at ¶ (1)(B)(i). The Secretary's regulations authorize the states to provide Medicaid to aged and disabled SSI recipients in accordance with SSI income standards while providing Medicaid to the aged and disabled medically needy in accordance with standards representing four-thirds of the corresponding AFDC standards. 45 C.F.R. § 812(b) and 814(b). Because Massachusetts has determined under the SSI program that the non-medical needs of the aged and disabled are higher than four-thirds of the AFDC standards, its SSI levels are higher than four-thirds of the AFDC standards. But Massachusetts has established its medically needy income standards for one and two person households at four-thirds of the corresponding AFDC standards.

18. The federal government annually increases the federal OASDI and SSI payments to take account of increases in cost of living. By contrast, Massachusetts does not increase the income standard for medically needy Medicaid applicants annually, and when it does increase the standard, it generally does so by a much lower percentage than the OASDI-SSI increase. Thus, while aged and disabled SSI recipients receive the benefit of

annual cost of living increases, medically needy aged and disabled OASDI recipients are deprived of all or much of their OASDI cost of living increases by the Massachusetts Medicaid requirement that they devote their increases to medical expenses.

19. Although the members of the plaintiff class would benefit substantially by foregoing all or part of their OASDI benefits and receiving SSI and categorically needy Medicaid instead, federal and Massachusetts law prohibit them from doing so. 42 U.S.C. § 1382(e)(2); 20 C.F.R. § 416.230; 42 C.F.R. § 435.603; Massachusetts Public Assistance Policy Manual, ch.IV, § B. p.4, ¶ 6.

20. Since the enactment of the Social Security Act in 1935, the federal government has encouraged wage earners covered by the Social Security tax to regard and rely on OASDI as security against the economic hazards and uncertainties of old age and disability, and covered wage earners, including the Plaintiff class, have so regarded and relied on OASDI. For Plaintiffs the discriminatory Medicaid income standards have made Social Security, not a shield against economic insecurity, but a liability which reduces their protection against such insecurity by precluding SSI eligibility, denying them the benefit of annual OASDI cost of living increases, and depriving them of the opportunity to receive or retain for their non-medical needs the amounts which Massachusetts has determined to be sufficient for such needs under the SSI program.

B. SIX MONTH SPEND-DOWN

21. Massachusetts determines medically needy eligibility on the basis of periods of six months. Under the Massachusetts Medicaid program a medically needy individual whose countable income exceeds the applicable Medicaid standard but whose medical expenses during any six month period will exceed six times the amount by which his monthly income exceeds the standard (i.e., six times his monthly "excess income") is eligible to have

Medicaid pay for medical expenses incurred above the six month excess income during the period.

22. The members of the plaintiff class have monthly medical expenses above their monthly "excess" incomes. These expenses occur with sufficient regularity that it can be reliably determined in advance that in any given six month period they will exceed six times their monthly "excess" incomes.

23. Yet Massachusetts refuses to pay any medical expenses for a medically needy person on "spend-down" status until he has incurred medical expenses in the amount of the entire six month spend down.

24. Most members of the plaintiff class receive their income monthly. They do not have sufficient income to provide for basic non-medical needs and to purchase medical needs or supplies in an amount six times their monthly "excess" income before receiving any medical assistance, and it is difficult or impossible for them to obtain sufficient credit for medical services and supplies to enable them to meet the Department's six month spend-down requirements.

25. As a consequence of the Massachusetts' six month spend-down requirement, many members of the plaintiff class never meet the "spend-down" requirement and are deprived of vital Medicaid benefits to which they are entitled. Other members of the plaintiff class are forced to sacrifice basic non-medical needs at the beginning of [the] six month period in order to meet the "spend-down" requirement.

VI. THE HOGANS

26. Mr. Hogan is 62 years old. He worked as a clerk from 1945 to 1952, and as a truck driver from 1952 to 1969, when he contracted disabling tuberculosis. Mrs. Hogan is 65 years old. From about 1945 to about 1952 she worked on a factory assembly line. From about 1965 to 1975 she worked as a clerk. During the periods that they worked Mr. and Mrs. Hogan paid Social Security taxes, and their employers paid Social Security taxes on

their behalf. Their only income is their Social Security benefits.

27. For three years prior to 1977, Mr. Hogan was confined to a sanitorium by his tuberculosis. Since 1977 he has been able to live outside a sanitorium only with extensive medical treatment. Mr. Hogan has a surgically-made cavity in his chest, which must be drained, medicated, packed and dressed daily. This operation requires the services of a professional nurse and a variety of medical supplies. The cost of this treatment and of Mr. Hogan's other medical expenses is substantially in excess of $1000 per month.

28. From 1977, to the present Mr. Hogan has received full Medicaid coverage. In June, 1979, Mr. Hogan was notified that, because of a change in Massachusetts regulations requiring that his wife's income be considered in determining his eligibility, the Department intended to terminate his full Medicaid coverage and accord him a "spend-down" status in which the Department [*sic*] he would be required to pay himself the first $1,205.40 of medical treatment in each six month period before the Department would provide him with any Medicaid coverage. Mr. Hogan appealed that decision, and, after three administrative hearings, the decision was upheld on April 4, 1980 by the Division's hearing referee.

29. In June 1979, Mr. Hogan's gross monthly income was $312.00 in OASDI benefits; his wife's gross monthly income was $283.90. Since the increase in OASDI benefits on July 1, 1979 Mr. Hogan's income has been $343.20, his wife's has been $303.40.

30. From 1977 until September 1979, the Massachusetts Medicaid income eligibility level for a couple was $375.00; in addition $20 of unearned income was disregarded. The regulations thus left the Hogans with $395.00 per month for their non-medical needs and required that they spend the remainder of their income for medical expenses in order to become eligible for Medicaid. By contrast, if the Hogans were eligible for SSI, they

would, under the benefit levels in effect prior to July 7, 1979, have received $491.73 ($471.93 plus $20 disregard) for their non-medical needs and full Medicaid coverage.

31. Since September 1979, the Massachusetts Medicaid income eligibility level for a couple has been $400.00. If the Hogans' eligibility were redetermined under the current standard, they would be left with $420 for their non-medical needs (including the $20 disregard). By contrast, if they were able to receive SSI at the benefit levels in effect since July 1, 1979, they would be allowed $524.04 ($504.04 plus $20 disregard) for their non-medical needs and full Medicaid coverage.

32. Even if the $395 per month alloted for their non-medical needs by the Massachusetts medical program were actually available to them, the Hogans would not be able to provide for their basic non-medical needs with that amount.

33. In fact, because of the Massachusetts practice of requiring the medically needly to incur medical expenses in an amount six times their monthly excess incomes before receiving any Medicaid benefits, even the $395 per month which the regulations purport to allow would be available to the Hogans only if they could obtain credit for their needed expenses. Applying its medically needy income standards, the Department has determined that Mr. and Mrs. Hogan have a monthly "surplus" income of $200.99 per month and have imputed to him a six month spend-down requirement of $1,205.40. The Department's practice is to refuse to pay any of Mr. and Mrs. Hogan's medical expenses until they have incurred medical expenses of $1,205.40, nearly twice the Hogan's total combined monthly income.

34. Since Mr. and Mrs. Hogan have more than $1,000 per month of regularly incurred medical expenses not subject to payment by third parties, and it can be determined with reasonable certainty that they will continue to incur these expenses over the next six months, it can be reliably determined that Mr. Hogan is eligible

for Medicaid coverage under the Department's present income guidelines. Yet the Department requires that he and his wife satisfy the entire six month surplus before receiving any Medicaid.

VII. THE BEBERMANS

35. Mr. Beberman is 75 years old; Mrs. Beberman is 77 years old. From about 1936 until 1974, Mr. Beberman worked as a route man distributing periodicals. During this time, Mr. Beberman paid social security taxes, and his employers paid social security taxes on his behalf. The Beberman's only income is their social security retirement and dependent's benefits.

36. As a result of complications following an operation for cancer, Mrs. Beberman has an incisional wound in her left leg. In order to avoid potentially fatal infection, the wound must be drained, packed, dressed, and medicated frequently. Mrs. Beberman also suffers from severe diabetes requiring her to take insulin by injection daily. She has several other debilitating ailments, including osteomilitus, which causes bone deterioration; and she is completely deaf in one ear. These ailments, and the general infirmities of old age, leave Mrs. Beberman in constant pain and unable to attend to her personal needs. Mr. Beberman is also in poor physical condition.

37. Mrs. Beberman depends on the assistance of a home health aid, who visits her daily to assist her with bathing and personal care, meal preparation, and her insulin shots, and a visiting nurse, who comes weekly to change the dressing on her wounds. Without this assistance Mrs. Beberman would be unable to live outside an institution.

38. Mrs. Beberman's expenses for regular medical care including the home health aid, the visiting nurse, bandages, and insulin, exceed $1300 per month. Prior to April 1, 1980, Mrs. Beberman was able to pay for some of her medical expenses through Medicare. However, Mrs. Beberman's limited Medicare coverage for

home health visits has expired, and she now has no Medicare or other insurance coverage for the great bulk of her medical expenses.

39. In June, 1979, the Beberman's combined income of $600 per month. [*sic*]. At that time the Department, under the regulations then in effect, determined that all but $395 per month of this income was "surplus" income which the Bebermans would have to devote to medical expenses in order to receive Medicaid. By contrast, if the Bebermans had been eligible to receive SSI in June, 1979, they would have receive $500.84, as an aged couple, ($480.84 plus $20 disregard) for their non-medical needs, plus full Medicaid coverage. The Bebermans appealed the Department's determination, but the decision was upheld by the Department's appeal referee.

40. The Beberman's current combined Social Security Income is $671.10. If the Beberman's eligibility were redetermined under the current Medicaid income standards, she and her husband would be allowed to keep only $420 of their income for their non-medical needs. By. contrast, if they were able to receive SSI, they would receive $533.78 ($513.78 plus $20 disregard) plus full Medicaid coverage.

41. The Bebermans are barely able to provide for their basic non-medical needs with their current income. They cannot provide for such needs with the $420 per month allowed by the Massachusetts Medicaid program.

42. When the $420 Medicaid exemption and disregard is deducted from the Bebermans' gross income of $671.10, the Bebermans have $249.90 per month in surplus income. However, under the Massachusetts practice of requiring the medically needy to incur expenses six times their monthly excess before receiving benefits, the Bebermans cannot receive Medicaid until they incur medical expenses of about $1,499.40 before receiving Medicaid benefits, more than twice their total monthly income. [*sic*].

VII. THE HUNTERS

43. Mr. Hunter is 69 years old; Mrs. Hunter is 69 years old. From 1931 to 1972 Mr. Hunter worked suc-

cessively as a hotel bell hop, a longshoreman, a bartender, a hotel clerk, and a clothing alteration checker. During this period Mr. Hunter paid Social Security taxes, and his employers paid Social Security taxes on his behalf. The Hunters' only income is their Social Security retirement and dependant's benefits.

44. Mr. Hunter's left leg was amputated in 1936. Despite this disability, he continued to work until 1972, when he lost his other leg in a car accident. He is confined to a wheelchair. He has serious glaucoma which requires extensive medication and treatment at a hospital an average of twice a month. He can only get from his home to the hospital by ambulance. Mr. Hunter's regular monthly medical expenses, including the cost of drugs and of ambulance transportation to the hospital, exceed $375 per month.

45. For many years Mr. Hunter received Medicaid benefits. In June 1979, the Department notified Mr. Hunter that his full Medicaid coverage would be terminated and he would be placed on spend down status with a six-month surplus of $450. Mr. Hunter appealed that decision and it was upheld by the Department's referee in October, 1979.

46. Mr. and Mrs. Hunter's total monthly income is $534.70 in Social Security retirement and dependent's benefits. This income, when reduced by the $20 disregard applied in Medicaid and SSI, is 92 cents above the applicable SSI income eligibility level of $513.78. If their income were one dollar less, the Hunters would be able to receive SSI; they could retain all their income, receive a nominal SSI payment, and receive full Medicaid coverage. But because their income exceeds the SSI standard by less than a dollar, Massachusetts requires that they spend all but $420 of their income for medical expenses before receiving Medicaid. Thus, a dollar of OASDI income costs them nearly $100 a month in benefits.

47. The Hunters' income is barely sufficient for their non-medical needs. Subsequent to the termination of his benefits in about October, Mr. Hunter was able to obtain a Medicaid coverage by incurring expenses for ambu-

lance transportation in the amount of his spend down. However, Mr. Hunter has no way of paying these bills and, because his ambulance service has refused to extend him further credit, he may be unable to incur further bills after his present eligibility period expires in order to meet the spend down for his next eligibility period.

IX. EQUITABLE RELIEF

48. The Plaintiff class is being deprived of health care and income to which they are entitled and which they need for survival at a poverty level. There is no adequate remedy at law.

49. If the Defendants Mahoney and Pratt are not enjoined from refusing to provide Medicaid benefits to the Plaintiffs on the same terms provided SSI recipients, the Plaintiffs will sacrifice vitally needed health care, non-medical needs or both. Many, including the named plaintiffs, may have to be institutionalized if they are not able to secure Medicaid on the same terms as SSI recipients.

X. CAUSES OF ACTION

COUNT I

50. The Plaintiffs reallege the allegations of Paragraphs 8 through 19 and 24 through 45 as if set forth herein at length.

51. The statutory four-thirds limit on reimbursement and the regulations of the Secretary and the Department on Medicaid income standards discriminate between identically situated aged and disabled individuals. This discrimination either deprives the Hogans and the members of the Plaintiff class of vital medical assistance or reduces incomes to below the amount which Massachusetts has determined under the SSI program as sufficient for their basic needs. The classification is triggered solely by the work performed and Social Security taxes paid by the disfavored class.

52. This discrimination is not rationally related to any legitimate legislative purpose. It violates the Plain-

tiffs' rights to the equal protection of the laws under the Fifth and Fourteenth Amendments to the United States Constitution.

COUNT II

55. The Plaintiffs reallege the allegations of Paragraphs 8 through 19 and 24 through 48 as if set forth herein at length.

56. The statute and regulations requiring the Plaintiffs' to apply for and accept all Social Security benefits for which they are eligible as a condition of application for SSI and Medicaid, 42 U.S.C. § 1382(e)(2); 20 C.F.R. § 416.230; 42 C.F.R. § 435.603; MPAPM, ch. IV, § B, p. 4, arbitrarily deprives the Plaintiffs of important health and income benefits afforded the identically situated class of aged and disabled SSI beneficiaries in violation of the Equal Protection requirements of the Fifth and Fourteenth Amendments to the United States Constitution.

COUNT III

57. The Plaintiffs reallege the allegations of paragraphs 19 through 45 as if set forth herein at length.

58. The Massachusetts practice of refusing to provide Medicaid benefits to medically needy individuals until they have incurred medical expenses six times their excess incomes violates the requirements of Title XIX of the Social Security Act that Medicaid programs which cover the medically needy must furnish assistance to the eligible medically needy; must determine eligibility pursuant to reasonable standards; must take into account only income and resources actually available to the recipients; must provide for flexibility in the application of Medicaid standards, and must take into account the costs actually incurred for medical care by applicants and recipients. 42 U.S.C. § 1395(a)(10) and (17).

WHEREFORE the plaintiffs pray that the Court:

1. Issue a preliminary injunction enjoining Defendants from failing to determine and provide Medicaid

benefits to the Plaintiffs Mr. and Mrs. Hogan and Mr. and Mrs. Beberman to the same extent that Massachusetts provides and pursuant to the same income and resource standards that Massachusetts applies to aged and disabled SSI recipients.

2. Certify this case as a class action.

3. Enter a declaratory judgment that the Massachusetts practice of determining and providing Medicaid benefits to the Plaintiff class pursuant to standards less favorable than the standards applied to aged and disabled SSI recipients and the provision of 42 U.S.C. § 1396b(f) which provides for federal reimbursement of payments to the medically needy on a basis less favorable than is provided for reimbursement of payments to the categorically needy violate the Equal Protection Guarantees of the Fifth and Fourteenth Amendments to the United States Constitution.

4. Enter a declaratory judgment that the statute and regulations requiring application for Social Security benefits as a condition of eligibility for SSI and Medicaid 42 U.S.C. § 1382(e)(2); 20 C.F.R. § 416.230; 42 C.F.R. § 435.603, MPAPM, ch. IV, § B, p. 4, violate the equal protection guarantees of the Fifth and Fourteenth Amendments to the United States Constitution.

5. Enter a declaratory judgment that the practice of the Massachusetts Department of Public Welfare of requiring Medicaid recipients on spend-down status to incur medical expenses in an amount six times their monthly "excess" incomes before providing Medicaid benefits, as applied to the plaintiff class, violates the Social Security Act.

6. Enter a permanent injunction enjoining the defendants from:

(a) failing to determine and provide Medicaid benefits to the members of the plaintiff class to the same extent that Massachusetts provides and pursuant to the income and recource standards Massachusetts applies to aged and disabled SSI recipients;

(b) failing to permit the members of the Plaintiff class to elect to waive such portion of their Social Security benefits as is necessary to reduce their incomes below the SSI income eligibility level and to provide SSI and Medicaid benefits to each member, when his or her income has been so reduced, on the same terms as provided to other SSI recipients; and

(c) failing to determine and provide for prompt payment on a monthly basis of medical expenses incurred by members of the plaintiff class in excess of his or her monthly excess income.

7. Award Plaintiffs' the cost of this action, including reasonable attorneys' fees.

8. Grant such further relief as the Court deems just and proper.

GEORGE HOGAN, PEARL HOGAN, CELIA BEBERMAN, HENRY BEBERMAN, GEORGE HUNTER and CECELIA HUNTER,
By their Attorneys,

/s/ William H. Simon
WILLIAM H. SIMON
Legal Services Institute
470 Centre Street
Jamaica Plain, MA 02130
(617) 522-3003

/s/ Mark Coven
MARK COVEN
Greater Boston Elderly Legal Services
102 Norway Street
Boston, MA (617) 536-0400

/s/ Gill Deford
GILL DEFORD
National Senior Citizens Law Centre
1636 West 8th Street, Suite 201
Los Angeles, CA 90017
(213) 388-1381

Ex. A p. 1

MASS STATE SUPPLEMENT - INDIVIDUALS
JULY 1978*

Living Arrangement	A Full Cost	B Shared Living	C Another's Household	E Rest Home
Aged				
State Standard	315.80	240.21	226.08	350.21
Federal SPA	189.40	189.40	126.27	189.40
State Increment	126.40	50.81	99.81	160.81
Blind				
State Standard	342.85	342.85	342.85	342.85
Federal SPA	189.40	189.40	126.27	189.40
State Increment	153.45	153.44	216.58	153.45
Disabled				
State Standard	303.65	231.03	211.96	350.21
Federal SPA	189.40	189.40	126.27	189.40
State Increment	114.25	41.63	85.69	160.81

*See R12999.31(f) for narrative.

Ex. A. p. 2

MASS STATE SUPPLEMENT - COUPLES
JULY 1978*

Living Arrangement	A Full Cost	B Shared Living	C Another's Household	E Rest Home
Aged/Aged				
State Standard	480.84	480.84	389.00	700.42
Federal SPA	284.10	284.10	189.40	284.10
State Increment	196.74	196.74	199.60	416.32
Blind/Blind				
State Standard	685.70	685.70	685.70	685.70
Federal SPA	284.10	284.10	189.40	284.10
State Increment	401.60	401.60	496.30	401.60
Disabled/Disabled				
State Standard	462.62	462.62	370.80	700.42
Federal SPA	284.10	284.10	189.40	284.10
State Increment	178.52	178.52	181.40	416.32
Aged/Blind				
State Standard	583.27	583.27	537.35	693.06
Federal SPA	284.10	284.10	189.40	284.10
State Increment	299.17	299.17	347.95	408.96
Aged/Disabled				
State Standard	471.73	471.73	379.90	700.42
Federal SPA	284.10	284.10	189.40	284.10
State Increment	187.63	187.63	190.50	416.32
Blind/Disabled				
State Standard	574.16	574.16	528.25	693.06
Federal SPA	284.10	284.10	189.40	284.10
State Increment	290.06	290.06	338.85	408.96

*See R12999.31(f) for narrative.

Ex. B, p.1

MASS STATE SUPPLEMENT - COUPLES
JULY 1979

Living Arrangement	A Full Cost	B Shared Living	C Another's Household	E Rest Home
Aged/Aged				
State Standard	513.78	513.78	415.64	700.42
Federal SPA	312.30	312.30	208.20	312.30
State Increment	201.48	201.48	207.44	388.12
Blind/Blind				
State Standard	732.68	732.68	732.68	732.68
Federal SPA	312.30	312.30	208.20	312.30
State Increment	420.38	420.38	524.48	420.38
Disabled/Disabled				
State Standard	494.30	494.30	396.20	700.42
Federal SPA	312.30	312.30	208.20	312.30
State Increment	182.00	182.00	188.00	388.12
Aged/Blind*				
State Standard	623.24	623.24	574.16	716.55
Federal SPA	312.30	312.30	208.20	312.30
State Increment	310.94	310.94	365.96	404.25
Aged/Disabled*				
State Standard	504.04	504.04	405.92	700.42
Federal SPA	312.30	312.30	208.20	312.30
State Increment	191.74	191.74	197.72	388.12
Blind/Disabled*				
State Standard	613.50	613.50	564.44	716.56
Federal SPA	312.30	312.30	208.20	312.30
State Increment	301.20	301.20	356.24	404.26

*If the total adds up to an odd amount, the system automatically rounds the blind spouse's benefit upward one cent.

Ex.B, p.2

MASS STATE SUPPLEMENT - INDIVIDUALS
JULY 1979

Arrangement	A Full Cost	B Shared Living	C Another's Household	E Rest Home
Aged				
State Standard	337.43	256.66	241.57	350.21
Federal SPA	208.20	208.20	138.80	208.20
State Increment	129.23	48.46	102.77	142.01
Blind				
State Standard	366.34	366.34	366.34	366.34
Federal SPA	208.20	208.20	138.80	208.20
State Increment	158.14	158.14	227.54	158.14
Disabled				
State Standard	324.45	246.86	226.48	350.21
Federal SPA	208.20	208.20	138.80	208.20
State Increment	116.25	38.66	87.68	142.01

EXHIBIT C

Massachusetts Public Assistance Policy Manual
Rev. 12/77

Chapter IV — Section B
Page 16

STANDARDS FOR EVALUATING INCOME

c. *Standards for Determining Net Income for Disabled Child*

When a family qualifies for AFDC, MA categorically related to AFDC, or MA under 21, and there is a disabled child in the family who qualifies for SSI, the family is to be advised of their right to select the eligibility arrangement which is financially most advantageous. The family has the option whether or not to apply for the SSI grant for the disabled child.

d. *Exemption of Net Income*

(1) *Persons in the Home*

An individual who needs care in his home or in an acute care facility has a net income exemption of $300.00 a month which is retained by the individual for his maintenance. The net income exemption for a family of two (2) shall be $375.00 a month and for a family of three (3) shall be $390.00 a month. Beyond this, there is a net income exemption of $50.00 for each additional dependent member of the family.

(2) MONTHLY NET INCOME EXEMPTION TABLE FOR PERSONS PARTICIPATING IN MA

No. of Persons	1	2	3	4	5	6	7	8	9	10
Exemption	300	375	390	440	490	540	590	640	690	740

e. *Application of Net Income*

(1) First, for maintenance needs as specified in chart above.

(2) Income in excess of that needed for maintenance will be applied next to:

(a) costs incurred for medical insurance premiums and enrollment fees;

(b) costs incurred for necessary medical or remedial care recognized under State Law, but not provided for in Chapter VII; and

(c) the cost of medical care to family members who are included in the computation of income but are not eligible for the MA program.

(3) All of the remaining excess income will be applied to costs of medical assistance provided for in the Medical Care Plan for eligible individuals.

EXHIBIT D

Massachusetts Public Assistance Policy Manual
Rev. 12/79

Chapter IV — Section B
Page 16

STANDARDS FOR EVALUATING INCOME

c. *Standards for Determining Net Income for Disabled Child*

When a family qualifies for AFDC, MA categorically related to AFDC, or MA under 21, and there is a disabled child in the family who qualifies for SSI, the family is to be advised of their right to select the eligibility arrangement which is financially most advantageous. The family has the option whether or not to apply for the SSI grant for the disabled child.

d. *Exemption of Net Income*

(1) *Persons in the Home*

An individual who needs care in his home or in an acute care facility has a net income exemption of $317.00 a month which is retained by the individual for his maintenance. The net income exemption for a family of two (2) shall be $400.00 a month and for a family of three (3) shall be $420.00 a month. There is a net income exemption of $62.00 for each additional dependent member of the family after 10.

(2) MONTHLY NET EXEMPTION TABLE FOR PERSONS PARTICIPATING IN MA AND NOT RECEIVING CHRONIC CARE IN A MEDICAL FACILITY

No. of Persons	1	2	3	4	5	6	7	8	9	10
Exemption	317	400	420	440	490	543	604	666	728	789

e. *Application of Net Income*

(1) Take the net income and compare it to the Monthly Net Income Standard.

(2) Income in excess of the standard can be applied towards the monthly costs incurred for medical insurance premiums and enrollment fees.

(3) The income remaining after (1) and (2) is called the monthly excess. The monthly excess times six is called surplus income. Surplus income will be applied next to:

(a) costs incurred for necessary medical or remedical care recognized under State law, but not provided for in the Massachusetts Medical Assistance Medical Care Plan; and

(b) the cost of medical care to family members who are included in the computation of income but are not eligible for the MA program.

(4) All of the remaining surplus income will be applied to costs of medical assistance provided for in the Medical Care Plan for eligible individuals

[Filed May 20, 1980]

AFFIDAVIT OF GEORGE HOGAN IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

GEORGE HOGAN, under pains and penalties of perjury, deposes and says as follows:

1. I am 62 years old. From 1945 to 1952, I worked as a clerk, and from 1952 to 1969, I worked as a truck driver. I had to stop working in 1969 because I contracted tuberculosis. Since then, my only income has been from Social Security benefits.

2. My wife Pearl Hogan is 65. From 1945 to about 1952 she worked on a factory assembly line, and from about 1965 to 1975 she worked as a clerk. Her only income comes from Social Security retirement benefits.

3. During the periods we worked, my wife and I paid Social Security taxes, and our employers paid Social Security taxes on our behalf. During this time, we relied on our Social Security rights to provide for us in the event of disability and/or retirement.

4. For three years prior to 1977, I was confined in a sanitorium because of my tuberculosis and related complications. I am presently able to live outside a medical institution only with extensive medical help. As a result of the treatment of my tubercular condition, I have an intrapleural fistula. This is a surgically made cavity 10 inches in diameter which opens on my chest. In order to prevent infection, I have to have a daily antibacterial dressing change in which the cavity is drained, medicated, packed, and dressed. The dressing change has to be performed by a nurse and requires a variety of medical supplies and medications. The cost of this daily dressing change and my other medical expenses exceeds $1,000 per month. A complete list of my own and my wife's monthly medical expenses is attached to this affidavit at Exhibit A.

5. From 1977 to the present, I have received full Medicaid coverage which paid for most of my medical expenses. Last year, the Department of Public Welfare notified me that because of a change in the regulations concerning the treatment of my wife's income, my Medicaid coverage was being terminated and that I could not receive further assistance until I had incurred $1,205.40 in medical expenses on my own. I appealed this proposed action, but on about April 5, I was notified that my appeal had been denied and that my coverage would terminate effective at the end of April.

6. My wife's and my total combined income is $646.60 in Social Security. This income is barely sufficient to pay for our monthly expenses for basic-non-medical needs and the medical expenses not covered by Medicaid. These expenses include food, $258; rent, $153; electricity, $22; phone, $25; laundry and cleaning $5; toiletries and personal care, $20; newspaper, $10; cigarettes $25; transportation, $20; medical expenses not covered by third-party payment (including dentist, vitamins, Mylanta, deductible portion of my wife's physician fees, my wife's insurance premiums), $70; miscellaneous (including clothing, household items, and repairs), $70. I have no private health insurance, and I have been told that my Medicare will not cover most of my medical expenses. I do not have any way to pay for my medical expenses without Medicaid.

SIGNED UNDER PAINS AND PENALTIES OF PERJURY THIS 29TH DAY OF APRIL, 1980.

/s/ George Hogan
GEORGE HOGAN

Exhibit A, p. 1

MEDICAL EXPENSES -- GEORGE AND PEARL HOGAN

MR. HOGAN:

Dressings, etc., for chest

	Price	Quantity	Cost per Month (One Change per Day)
Vaseline pads	$ 7.95/12	2 per change	$ 37.00
3" gauze bandages	$ 7.95/12	2 per change	$ 37.00
4" gauze bandages	$ 6.50/12	2 per change	$ 34.00
mycolog (antibiotic cream)	$15./tube	2 tubes per month	$ 30.00
liste: packs (lge.)	$ 1.75 ea.	1 per change	$ 53.00
cloth tape	$ 1./roll	1/2 roll per change	$ 15.00
AVD pads	$ .50 ea.	1 per change	$ 15.00
gloves	$ .10 ea.	4 per change	$ 12.00
50 cc. syringes*	$ .75 ea.	1/4 - 1 per ch.	$5-$23.00
Bededine solution	$ 3.95/btl.	60 bottles/mo.	$ 24.00
vaseline	$ 1.50/btl.	1 per month	$1.50
bags (for used bandages)			$1.50
			$265.00

*Supposed to be used only once; Mr. Hogan can boil and use four times.

Medicines

propxyphene (pain re chest)	$ 3.70/50	4/day	9.00
Zymalixer (iron tonic re chest)	$ 9.00 bot.	+6/month	9.00
Nitroglycerine (heart)	$ 1.39/100	5/month	.07
			$18.07

Miscellaneous

Elastic Stocking (heart)	$ 6.95 pr.	1/month av r.	6.95

Exhibit A, p. 2

Nurse	$25.00 visit	per 1 day	$,750.00
Doctors			
Thoracic Surgeon	$60.00 visit	every 2 months	$ 30.00
Primary care	$60.00 visit	"	$ 3..00
X-Ray	$45.00	every 3 months	$ 15.00
Misc. laboratory			$10.00
			$85.00
Medicare premium			
MRS. HOGAN:			
Blue Cross/ Blue Shield prem.	$96.00 quarter		$32.00
Maalox	$ 2.15/100	100/wk.	9.25
			$41.25
		TOTAL	$1,165.27

[Filed May 20, 1980]

AFFIDAVIT OF GEORGE C. HUNTER

I, George C. Hunter, do hereby depose and state that:

1. I reside at 15 ½ Dacia Street, Dorchester, MA. My social security number is 012-18-5582 A.

2. I live with my wife, Mrs. Cecilia Hunter.

3. Both my wife and I will be 69 years of age in July, 1980.

4. I presently have income from Social Security benefits of $291.21

5. My wife has Social Security benefits of $243.50.

6. The total combined income for my wife and I is $534.70.

7. In 1936, I had my leg amputated as a result of osteomilitis. I was able to continue working, however, at Filenes up until 1972.

8. In 1972, I was in a very serious car accident which required the amputation of my right leg.

9. This has left me a double amputee confined to a wheelchair for the rest of my life.

10. Because I had worked for so many years I applied for Social Security disability benefits in 1972, as I was only 61 years of age at that time.

11. In January, 1974, I began receiving Supplemental Security Income in the amount of approximately $70 each month. I stayed on SSI until June of 1974 when I was cut off because it was determined that I was receiving too much income.

12. In July of 1976, I was taken off Social Security Disability benefits and I began to receive Social Security Retirement benefits because I had become 65 years of age.

13. Even though I had lost my SSI benefits in June of 1975, I still continued to receive my medicaid benefits.

14. However, in May of 1979, I received notification that I was no longer eligible for medicaid because my income was too high.

15. At that time in May of 1979, the total income of my wife and I was $470 each month.

16. We were told by Medicaid that although I would no longer automatically be receiving a medicaid card, my wife and I would be eligible for medicaid if we incurred medical expenses in the amount of $450 for six months. This was referred to as our spend-down figure.

17. In September, 1979, I requested a hearing because I desperately needed my medicaid benefits but could not afford to pay out $450 before we were able to receive a medicaid card.

18. On October, 1979, we received the decision from the appeals referee that the decision of the Department of Public Welfare had been upheld.

19. In April, 1980, I sent over $450 worth of bills to the Welfare Department, and I received a medicaid card for the month of April.

20. I am presently confined to a wheelchair. I require scheduled medication at the Boston City Hospital for glaucoma and other serious conditions approximately once a week.

21. My only way of reaching Boston City Hospital is by being taken there by an ambulance.

22. I have always been taken to Boston City Hospital by the Fallon Ambulance Company. The bills for the ambulance transportation was always billed to Medicaid.

23. However, after I lost my medicaid benefits, Fallon Ambulance refused to take me to Boston City Hospital, until April when I got my new medicaid card.

24. I require transportation by ambulance to the hospital on the average of twice each month. The cost for this transportation averages $162 for a round trip for a total of $324 per month. I do not know how I will be able to pay for the transportation to the hospital. I cannot afford to pay privately for ambulance service because the total income of my wife and I is $534 and the transportation service per month alone is $324.

25. As a result of my severe glaucoma, I also have high expenses for prescription drugs. They include the following:

eye drops for glaucoma	—	$26 per month
insulin for diabetes	—	$3 per month
HCTZ for hypertension	—	$6 per month
Diamox for glaucoma	—	$19.20 per month
Total drug expenses	—	$54.20

26. My total medical expenses, including ambulance service and prescription drugs come out to be at least $378 per month. I simply cannot afford to pay this when our total income is only $534 per month. I am terribly afraid that I will not be able to get my medical care without medicaid and I am desparately afraid of what will happen if I cannot get my scheduled medication at the Boston City Hospital.

27. I have other expenses for my daily living requirements as well as my medical expenses. These expenses include:

rent	—	$125
gas & electricity	—	25
telephone	—	42
oil	—	150
Total monthly expenses		$342

These figures do not include my cost of clothing, food and other normal monthly expenses.

28. If you total my medical expenses of a minimum of $378 each month and my other fixed expenses of $342 each month, my total expenses for each and every month is at a minimum of $720.

29. Despite this fact, I am told that I am over income to receive medicaid. This doesn't make any sense to me because I cannot live on the amount of income that I am presently receiving with the amount of medical expenses that I have.

30. I have called Social Security Administration to find out if I would be eligible for Supplemental Security

Income and thereby would be able to receive a medicaid card based on my eligibility for SSI. I was told that the income limit for my wife and I to be eligible for SSI is $513.78. I was told that if you took a $20 deduction from our income, it would bring our countable income to $514.70. This means that I am less than $1 over the income limits for SSI, yet because of this $1, I am ineligible to receive SSI and thus am not able to receive medicaid as a result of receiving SSI.

31. On May 5, 1980, I received notice from the Welfare Department that my spend-down was re-evaluated based on my new total income of $534.70. I have been told that the medicaid income limit for two people is $400 which put me $97.30 over the income limit, after the $20 disregard and Medicare deductibles. The notice stated that my surplus income for the period from May 1, 1980 to November 1, 1980 was $582.00

32. This means that under the new figures I will have to spend or incur $582.00 in bills before I can receive a medicaid card. This makes absolutely no sense to me. I do not have enough income to pay $582.00 before I can get medicaid.

33. I did not get a medicaid card for the month of May. When the Fallon Ambulance Company finds out that I am no longer on medicaid, they will stop transporting me to the hospital, like they did until April.

34. The Fallon Ambulance Company will not give me transportation on credit and I do not have enough income to pay them up front. I thereby cannot get ambulance transportation without having medicaid. If I don't get the transportation I won't get the bills to meet my spend-down. And medicaid tells me that I must have the bills before I can get a medicaid card. But I can't get the bills without a medicaid card. I am trapped in this vicious circle.

35. I do not understand how this system operates. If I was able to get SSI I would get full medicaid coverage. However, I am $0.92 over the limit to receive medicaid.

However, they will not let me spend-down the $0.92 in order to get SSI and medicaid. However, because I receive Social Security benefits over the SSI limit, I must spend-down $582.00 before I can get a medicaid card. I don't know what I will do if I can't get medicaid. I can't get bills to meet the spend-down of $582.00 because I can't get ambulance transportation on credit and I don't have the income to pay for those bills up front. I barely have the income to survive, even if I do get a medicaid card. If I don't get medicaid, I won't be able to get to the hospital and I won't be able to get my scheduled medication. I am terribly afraid and I don't know what to do.

Signed and sworn under the pains and penalties of perjury.

/s/ George C. Hunter
GEORGE C. HUNTER

DATED: This 16th day of May, 1980.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No. 80-883-T

[Filed July 3, 1980]

GEORGE HOGAN, ET AL., PLAINTIFFS

v.

PATRICIA HARRIS, ET AL., DEFENDANTS

STATEMENT OF MATERIAL FACTS NOT IN DISPUTE

1. Plaintiff George and Cecilia Hunter have a combined monthly income from Social Security benefits of $534.70. Mr. Hogan is a double amputee confined to a wheelchair, and he also suffers from glaucoma. He must travel to the hospital for treatment twice a month, and can only get there by ambulance. In addition, he has bills for medicine of over $50 per month.

2. Plaintiffs George and Pearl Hogan have an [*sic*] combined monthly income of $646.60 from social security benefits. Mr. Hogan has a large cavity in his chest from surgical treatment of tuberculosis. The cavity requires a daily anti-bacterial dressing change which must be performed by a trained nurse. His medical expenses exceed $1000 per month.

3. Plaintiffs Henry and Celia Beberman have a combined monthly income from social security benefits of $668.10. Mrs. Beberman suffers several deblitating [*sic*] conditions which require daily assistance of a home health aid and weekly visits by a nurse. Her expenses for medical care exceed $1300 per month.

4. Under the Massachusetts Title XIX plan for medical assistance (Medicaid plan), medically needy couples such as those who are plaintiffs in this action are eligible for medical assistance when they have incurred medical expenses sufficient to reduce their available income to $400.00. The level of eligibility for the medically needy set by Massachusetts is 133⅓ (4/3) of its AFDC pay-

ment to a comparably sized family, and is the maximum level at which the state will receive federal matching funds, as provided in 42 U.S.C. 1396b(f).

5. An aged, blind, or disabled couple with no income receiving Supplemental Security Income (SSI) benefits will receive a federal SSI payment of $312.30 maximum. In addition, an aged couple will receive a maximum state supplement of $201.48. The state supplement for a disabled/aged couple is $191.74. Thus the eligibility level for cash assistance for an aged couple in Massachusetts, including the state supplement, is $513.78 per month, and for a disabled aged couple is $504.04 per month. Persons receiving SSI or state supplementary payments are eligible for Medicaid as categorically needy (the latter group by state option).

6. The foregoing facts are pertinent to the time when the complaint was filed. On July 1, 1980 SSI and Social Security (Title II) benefits increased.

Respectfully submitted,

ALICE DANIEL
Assistant Attorney General
EDWARD F. HARRINGTON
United States Attorney

/s/ Lewis K. Wise
LEWIS K. WISE

/s/ John B. Maclay
JOHN B. MACLAY
Attorneys, Department of Justice
Civil Division
10th & Pennsylvania Avenue, N.W.
Washington, D.C. 20530
Telephone: (202) 633-3350

Attorneys for Defendants

Of Counsel:

Nancy Nemon
Deputy Regional Attorney
Department of Health &
Human Services

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil No. 80-883-T

[Filed July 25, 1980]

GEORGE HOGAN, ET AL., PLAINTIFF

v.

PATRICIA HARRIS, ET AL., DEFENDANTS

PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

Pursuant to Rule of Procedure 56, the Plaintiffs move that the Court grant summary judgment for the Plaintiffs on Counts I and II of the Complaint and enter the Proposed Order submitted herewith on the grounds that there is no genuine issue of material fact and the Plaintiffs are entitled to judgment as a matter of law. In support of this motion, the Plaintiffs rely on their complaint, the affidavits of George Hogan, Celia Beberman, George Hunter, Joanne Doyle, and John Polk; and the Plaintiffs' three memoranda submitted herein.

By their Attorneys,

GILL DEFORD
National Senior Citizens
Law Center
1636 West 8th Street,
Suite 201
Los Angeles, CA 90017
(213) 388-1381

WILLIAM H. SIMON
Legal Services Institute
470 Centre Street
Jamaica Plain, MA 02130
(617) 522-3003

MARK COVEN
Greater Boston Elderly
Legal Services
102 Norway Street
Boston, MA
(617) 536-0400

SUPREME COURT OF THE UNITED STATES

No. 81-213

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, APPELLANT

v.

GEORGE HOGAN, ET AL.

Appeal from the United States District Court for the District of Massachusetts

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted.

October 13, 1981

☆ U. S. GOVERNMENT PRINTING OFFICE: 1981 339040 696

Motion to Dismiss or Affirm

Office-Supreme Court, U.S.
FILED
SEP 4 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-213

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT,

v.

GEORGE HOGAN, ET AL., APPELLEES

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

The appellees George Hogan, Pearl Hogan, George Hunter and Cecelia Hunter, on behalf of themselves and the class they represent, ask leave to file the Motion to Affirm submitted herewith and to proceed in forma pauperis as permitted by Rule 46.

Leave to proceed in forma pauperis was granted by the Court below. The appellees' affidavits in support of this motion are attached hereto.

By their attorney,

William H. Simon
Stanford Law School
Stanford, California 94305
(415) 497-3627
Counsel for Appellees

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

APPELLANT,

V.

GEORGE HOGAN, ET AL.,

APPELLEES.

AFFIDAVIT IN SUPPORT OF MOTION TO
PROCEED IN FORMA PAUPERIS

I, Pearl Hogan, being first duly sworn, depose and say that I am an appellee in the above-entitled case; that in support of my motion to proceed on appeal without being required to prepay fees, costs or given security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe that I am entitled to redress; and that the issues which I desire to present on appeal are the following:

The validity under the Social Security Act and the 14th Amendment of the United States Constitution of the practice of the Massachusetts Medicaid program of denying to the class of aged and disabled Social Security recipients Medicaid benefits needed for survival at a subsistence level which Massachusetts provides to a group of identically situated recipients of Supplemental Security Income.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the costs of prosecuting the appeal are true.

1. Are you presently employed? No

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. 1975 $1,000 per month.

2. Have you received within the past twelve months any income from a business profession or other form of self-employment or in the form of rent payments, interest, dividends or other source? Yes

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months. Social Security: $386.00/month.

3. Do you own any cash or checking account? No

a. If the answer is yes, state the total value of the items owned.

4. Do you have any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishing and clothing)? No

a. If the answer is yes describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to these persons.

George Hogan, Husband.

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

SUBSCRIBED TO AND SWORN TO before me this 4th day of August, 1981.

Pearl Hogan

Cheryl A Burg

Cheryl A Burg
Notary Public
My Commission Expires 2-7-86

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

APPELLANT,

V.

GEORGE HOGAN, ET AL.,

APPELLEES.

AFFIDAVIT IN SUPPORT OF MOTION TO
PROCEED IN FORMA PAUPERIS

I, George C Hunter, being first duly sworn, depose and say that I am an appellee in the above-entitled case; that in support of my motion to proceed on appeal without being required to prepay fees, costs or given security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe that I am entitled to redress; and that the issues which I desire to present on appeal are the following:

The validity under the Social Security Act and the 14th Amendment of the United States Constitution of the practice of the Massachusetts Medicaid program of denying to the class of aged and disabled Social Security recipients Medicaid benefits needed for survival at a subsistence level which Massachusetts provides to a group of identically situated recipients of Supplemental Security Income.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the costs of prosecuting the appeal are true.

1. Are you presently employed? NO

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. 1972 $1,500 per month.

2. Have you received within the past twelve months any income from a business profession or other form of self-employment or in the form of rent payments, interest, dividends or other source? YES

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months. $ 2. 850 = monthly

3. Do you own any cash or checking account? YES

a. If the answer is yes, state the total value of the items owned. $ 3.7

4. Do you have any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishing and clothing)? NO

a. If the answer is yes describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to these persons.

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

SUBSCRIBED TO AND SWORN TO before me this 19TH day of August, 1981.

George C. Hunter

Mark L. Cover
Notary Public
My Commission Expires: 1-11-85

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

APPELLANT,

V.

GEORGE HOGAN, ET AL.,

APPELLEES.

AFFIDAVIT IN SUPPORT OF MOTION TO
PROCEED IN FORMA PAUPERIS

I, George Hogan, being first duly sworn, depose and say that I am an appellee in the above-entitled case; that in support of my motion to proceed on appeal without being required to prepay fees, costs or given security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe that I ar entitled to redress; and that the issues which I desire to present on appeal are the following:

The validity under the Social Security Act and the 14th Amendment of the United States Constitution of the practice of the Massachusetts Medicaid program of denying to the class of aged and disabled Social Security recipients Medicaid benefits needed for survival at a subsistence level which Massachusetts provides to a group of identically situated recipients of Supplemental Security Income.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the costs of prosecuting the appeal are true.

1. Are you presently employed? No

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. June, 1969 $400 per month

2. Have you received within the past twelve months any income from a business profession or other form of self-employment or in the form of rent payments, interest, dividends or other source? Yes

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months. Social Security $436.40/month.

3. Do you own any cash or checking account? No

a. If the answer is yes, state the total value of the items owned.

4. Do you have any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishing and clothing)? No

a. If the answer is yes describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to these persons.

Pearl Hogan, Wife

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

SUBSCRIBED TO AND SWORN TO before me this 4th day of August, 1981.

Margie T Hogan

Cheryl A Burg

Cheryl AJ Burg
Notary Public
My Commission Expires 2-7-86

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

APPELLANT,

V.

GEORGE HOGAN, ET AL.,

APPELLEES.

AFFIDAVIT IN SUPPORT OF MOTION TO
PROCEED IN FORMA PAUPERIS

I, CECELIA HUNTER, being first duly sworn, depose and say that I am an appellee in the above-entitled case; that in support of my motion to proceed on appeal without being required to prepay fees, costs or given security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe that I am entitled to redress; and that the issues which I desire to present on appeal are the following:

The validity under the Social Security Act and the 14th Amendment of the United States Constitution of the practice of the Massachusetts Medicaid program of denying to the class of aged and disabled Social Security recipients Medicaid benefits needed for survival at a subsistence level which Massachusetts provides to a group of identically situated recipients of Supplemental Security Income.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the costs of prosecuting the appeal are true.

1. Are you presently employed? NO

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. None

2. Have you received within the past twelve months any income from a business profession or other form of self-employment or in the form of rent payments, interest, dividends or other source? YES

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months. $5,272.23

3. Do you own any cash or checking account? YES

a. If the answer is yes, state the total value of the items owned. $20.00

4. Do you have any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishing and clothing)? NO

a. If the answer is yes describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to these persons.

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

SUBSCRIBED TO AND SWORN TO before me this 19th day of August, 1981.

x Cecelia Hunter

Notary Public

My Commission Expires: 1-11-85

No. 81-213

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT,

v.

GEORGE HOGAN, ET AL., APPELLEES

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MOTION TO AFFIRM

William H. Simon
Stanford Law School
Stanford, California 94305

Gary Bellow
Legal Services Institute

Mark Coven
Greater Boston Elderly
Legal Services

Gill Deford
National Senior Citizens
Law Center

TABLE OF CONTENTS

	Page
MOTION TO AFFIRM	1
QUESTION PRESENTED	1
BASIS OF MOTION	1
STATEMENT OF THE CASE	2
THE QUESTION IS NOT SUBSTANTIAL	7
A. THE DISCRIMINATION IS A "LEGISLATIVE ACCIDENT"	9
B. THE DISCRIMINATION IS NOT RATIONALLY RELATED TO THE PURPOSES HYPOTHESIZED BY THE GOVERNMENT	20
CONCLUSION	25

TABLE OF AUTHORITIES

CASES:

Aitchison v. Berger, 404 F.Supp. 1137 (S.D.N.Y. 1975), aff'd 538 F.2d 307 (2d Cir.), cert. denied 429 U.S. 890 (1976)	6
Brown v. Beal, 404 F. Supp. 770 (E.D. Pa. 1975)	6
Caldwell v. Blum, 621 F.2d 491 (2d Cir. 1980), cert. denied, 49 L.W. 3894 (1981)	6
Califano v. Boles, 443 U.S. 282 (1979)	23
Califano v. Jobst, 434 U.S. 47 (1977)	7
Califano v. Westcott, 443 U.S. 76 (1979)	8
Delaware Tribal Business Commission v. Weeks, 430 U.S. 73 (1976)	9
Doe v. Plyler, 628 F.2d 448 (5th Cir. 1980)	20
Fullington v. Shea, 320 F. Supp. 500 (D. Col. 1970), aff'd 404 U.S. 963 (1971)	7
Harris v. McRae, 448 U.S. 297 (1980)	9
Jefferson v. Hackney, 406 U.S. 535 (1972)	12
Medora v. Colautti, 602 F.2d 1149 (3d Cir. 1979)	20
Morales v. Minter, 393 F. Supp. 88 (D. Mass. 1975)	20
Rinaldi v. Yeager, 384 U.S. 305 (1969)	20
Rosado v. Wyman, 397 U.S. 397 (1970)	12
Schaak v. Schmidt, 344 F. Supp. 99 (E.D. Wis. 1971)	16
Schweiker v. Wilson, ____ U.S. ____, 101 S.Ct. 1074 (1981)	2, 9, 20, 21
Shapiro v. Thompson, 349 U.S. 618 (1969)	20
U.S. Railroad Retirement Board v. Fritz, ____ U.S. ____, 101 S.Ct. 453 (1980)	2, 21

CONSTITUTION, STATUTES AND REGULATIONS

United States Constitution:	
Fifth Amendment	1, 6
Fourteenth Amendment	1, 6
Pub.L. 97.35, section 2173, 97th Cong., 1st Sess. (1981)	16, 17
Pub.L. 96-499, section 945, 96th Cong., 2nd Sess. (1980)	21, 22

CONSTITUTION, STATUTES AND REGULATIONS--CONTINUED

Pub.L. 90-248, 90th Cong., 1st Sess. (1967). 18

Social Security Act, 42 U.S.C. 301 et seq.:
Title I, 42 U.S.C. 301 et seq. 3
Title II, 42 U.S.C. 401 et seq. 3
42 U.S.C. 402(a) 3
42 U.S.C. 402(q) 3
42 U.S.C. 416(i) 3
42 U.S.C. 423. 3
Title XIV, 42 U.S.C. 1351 et seq. 3
Title XVI, 42 U.S.C. 1381 et seq. 2
42 U.S.C. 1382 c(c). 3
42 U.S.C. 1382c(j) 3
42 U.S.C. 1382c(s) 3
42 U.S.C. 1382(a). 3, 4
42 U.S.C. 1382e. 6
42 U.S.C. 1382(f). 14
Title XVIII, 42 U.S.C. 1395 et seq.
42 U.S.C. 1395c. 21
42 U.S.C. 1395p. 22
42 U.S.C. 1395o. 21
42 U.S.C. 1395v. 17, 21
Title XIX, 42 U.S.C. 1396 et seq. 4
42 U.S.C. 1396a. 4, 16, 17, 18
42 U.S.C. 1396b. 4, 5, 17, 21

Mass. G.L c.118A, section 1. 3

20 C.F.R. 416.2001 et. seq. 4
42 C.F.R. 405.210. 22
42 C.F.R. 435.812-14 17
42 C.F.R. 435.831(c) 5, 8, 21, 24

Massachusetts Public Assistance Policy Manual:
Ch. IV, section B, p. 4 6
Ch. IV, section B, p. 16, ¶ d 7
Ch. IV, section B, p. 17, ¶ e 8

MISCELLANEOUS:

Blue Cross and Other Private Health Insurance for the Elderly: Hearings Before the Subcommittee on Health of the Elderly of the Senate Committee on Aging, 89th Cong., 2d Sess. (1964) 23, 24, 25
Conf. Comm. Rep. No. 1030, 90th Cong., 1st Sess. (1967). 12
113 Cong. Rec. (1967). 10, 13, 15, 19
127 Cong. Rec. (1981). 16
H. Rep. No. 544, 90th Cong., 1st Sess. (1967). . . 12, 14
H. R. 10208, 90th Cong., 1st Sess. 1960. 18
Medical Care for the Aged: Hearings Before the Committee on Ways and Means, 89th Cong., 1st Sess. (1965). 23, 24, 25
President's Proposals for Revision of the Social Security System: Hearings on H. R. 5710 Before the House Committee on Ways and Means, 90th Cong., 1st Sess. (1967). 10
Senate Special Committee on Aging, Private Health Insurance Supplementary to Medicare (Committee Print 1974) 25
S. Rep. No. 404, 89th Cong., 1st Sess (1965) . . . 16, 17

S. Rep. No. 744, 90th Cong., 1st Sess. (1967). . . 12, 14
Social Security Amendments of 1967: Hearings on H. R. 10208 Before the Senate Committee on Finance, 90th Cong., 1st Sess. (1967) 11, 12

CCH Medicare and Medicaid Guide. 13
H. Denenberg, et al., Risk and Insurance (3rd ed. 1974) 24
Liebman, "The Definition of Disability in Social Security and Supplemental Security Income," 89 Harv. L. Rev. 833 (1976). 8
Martin, "Public Assurance of Adequate Minimum Income In Old Age," 64 Cornell L. Rev. 437 (1979). 4
Reed and Myers, "Health Insurance Coverage Complementary to Medicare," 30 Social Security Bulletin 3 (August 1967) 25
R. Stevens and R. Stevens, Welfare Medicine in America (1974). 10
Urban Systems Research and Engineering, AFDC Standards of Need (Study Prepared for Office of Research and Statistics, Social Security Administration (1980) . 15

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

No. 81-213

RICHARD SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT,

v.

GEORGE HOGAN, ET AL., APPELLEES

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MOTION TO AFFIRM

The plaintiffs George and Pearl Hogan and George and Cecelia Hunter, on behalf of themselves and all others similarly situated, move that the judgment of the District Court be affirmed pursuant to Rule 16 of this Court on the ground that it is manifest that the questions on which the decision of the cause depends are so unsubstantial as not to need further argument.

QUESTION PRESENTED

Whether the equal protection requirements of the Fifth and Fourteenth Amendments permit Congress to require and Massachusetts to apply in its Medical Assistance program a much more stringent income eligibility standard for aged and disabled Social Security recipients who are not eligible for Supplemental Security Income than it applies for aged and disabled Supplemental Security Income recipients.

BASIS OF MOTION

We recognize that an appeal from a decision sustaining an equal protection challenge to a non-suspect classification in a welfare program will rarely fail to present a substantial question. Nevertheless, we submit that this is an unusual case in which further review is not warranted because the court below applied the minimum rationality analysis approved by the Court this term in

U.S. Railroad Retirement Board v. Fritz, _____ U.S. _____, 101 S.Ct. 453 (1980), and Schweiker v. Wilson, _____ U.S. _____, 101 S.Ct. 1074 (1981), and was plainly correct in concluding that, even under the standard of legislative deference required by those cases, the discrimination against the appellees lacks a rational basis.

Pursuant to a restriction in Title XIX of the Social Security Act, the Massachusetts Medical Assistance program applies a much more stringent income eligibility standard--far below the applicable state-defined subsistence standard--to the appellee class of aged and disabled Social Security recipients than it applies to aged and disabled Supplemental Security Income (SS) recipients, although the appellees are identically situated to the SSI recipients in terms of every factor which the regulatory scheme itself makes relevant. On the basis of a careful review of the legislative history (which is erroneously described in the Jurisdictional Statement, see pp. 10-16, 19-20 below), the District Court determined that Congress did not intend or anticipate this discrmination. The Court then considered the justifications for the discrimination which the Secretary advances in the Jurisdictional Statement and properly concluded that the discrimination is patently arbitrary even in regard to these hypothetical purposes. The Court's decision thus rests, not solely on the absence of any actual Congressional purpose, but on the failure of government counsel to articulate even a hypothetical rational basis for the discrimination.

STATEMENT OF THE CASE

This case arises from the intersection of three federal programs: Old Age, Survivors, and Disability Insurance (OASDI or Social Security): Supplemental Security Income (SSI); and Medical Assistance (Medicaid).

Social Security is the basic social insurance program estab-

lished by Title II of the Social Security Act of 1935 and subsequent amendments to provide income security for the aged and disabled and their survivors and dependents. Primary entitlement depends on attainment of age 65 (or for reduced benefits, age 62), 42 U.S.C. 402(a), (q)(1), or on disability, 42 U.S.C. 416(i), 423. Benefits are financed by taxes which workers and employees are required to pay, and eligibility also depends on having engaged in a requisite amount of employment covered by the tax.

SSI is the federal public assistance program for the aged and disabled established by Title XVI of the Social Security Act in 1972. It is the successor to the Old Age Assistance and Aid to the Permanently and Totally Disabled programs originally established by Titles I and XIV of the Social Security Act in 1935. As for Social Security, eligibility for SSI depends on attainment of age 65 and on disability, which is defined identically to the Social Security definition. 42 U.S.C. § 1382c(a), (j), and (s). Unlike Social Security, however, SSI payments are not based on recipient's work history or tax payments. SSI eligibility depends on financial need, as measured by the SSI income standards. An aged or disabled person or couple is financially eligible when his or her income (less certain exemptions and disregards) is below the applicable standard. An eligible person or couple receives an SSI payment sufficient to bring its income up to the standards. Basic income standards are established by Congress, but states have the option (and in some instances, the obligation) to raise these standards by supplementary payments. See 42 U.S.C. § 1382(c).

Massachusetts law provides for the supplementation of SSI payment standards "based on need" as determined by the Department of Public Welfare. G.L.C. 118A, section 1. The state supplements are added to the federal levels to determine the Massachusetts SSI income and payment standards. Both state and federal payments are administered through a single application and payment process

by the same agency which administers Social Security, the Social Security Administration. See 20 C.F.R. § 416.2001 et seq.

In the SSI program, Social Security income is treated as "unearned income" which, after the application of a $20 per month disregard, is counted in full against the SSI income eligibility standard. Aged and disabled Social Security recipients whose countable income is below the SSI standard are eligible to receive an SSI grant in the amount of the difference between their countable incomes and the SSI standards; those whose incomes exceed the standards are ineligible for SSI. 42 U.S.C. 1382(a), 1382(a)(2)(B), 1382e. See generally Martin, "Public Assurance of Adequate Minimum Income in Old Age," 64 Cornell L. Rev. 437, 491-507 (1979).

Medicaid is a cooperative federal-state program established by Title XIX of the Social Security Act in 1965 which pays for the cost of medical treatment for certain categories of people whose income is insufficient to meet their needs. Medicaid is administered by the states under plans formulated by them but subject to federal statutory and regulatory requirements. The states are reimbursed by the federal government for a percentage of their expenses. 42 U.S.C. 1396b. Title XIX gives states a variety of options with respect to Medicaid coverage. The most basic classes of eligibility are the "categorically needy" and the "medically needy." The categorically needy include those eligible for benefits under the two principal federally supported cash assistance programs, Aid to Families with Dependent Children (AFDC) and SSI. The Massachusetts program covers all cash assistance recipients. SSI recipients thus receive a cash grant for their non-medical needs plus Medicaid coverage. The second class, the "medically needy," includes those who would be eligible for AFDC or SSI but for the amount of their income and who, when their medical expenses are considered, have insufficient income for basic needs. 42 U.S.C. § 1396a(a)(10). Title XIX permits states to cover the medically

needy, and Massachusetts has chosen to do so.

The premise of the medically needy program is that financial need be measured by income net of medical expenses. Financial eligibility for Medicaid as medically needy is determined by income standards designed to allow for the applicant's non-medical needs. To the extent that the applicant's income exceeds the standard, he or she is expected to use the "surplus" for medical expenses. Once he or she has incurred medical expenses in excess of surplus income, he or she is eligible for Medicaid for his or her remaining expenses. In the jargon of the program, the medically needy may establish eligibility by "spending down" for medical expenses the amount by which their income exceeds the applicable income standards. See 45 C.F.R. 435.831; District Court Opinion, Jurisdictional Statement, Appendix A (hereinafter "Opinion"), at 6a-7a. The medically needy income standards thus determine the amount afforded to the medically needy for non-medical needs.

This case arises from the fact that the Massachusetts medically needy income standards are far more stringent than the Massachusetts SSI standards--in the case of the appellee couples by about $100 or more a month. These lower medically needy standards are required by a 1967 amendment to Title XIX which permits a state to provide Medicaid in accordance with its cash assistance standards to the categorically needy but precludes, as a condition of federal reimbursement, medically needy standards in excess of 133 1/3 percent ("four-thirds") of the state's maximum AFDC payment standards. 42 U.S.C. 1396b(f). Because in Massachusetts 133 1/3 percent of the AFDC standard is below the SSI standards, the medically needy eligibility standards required by the four-thirds maximum force aged and disabled people with Social Security incomes above the SSI standards to spend down far below those standards. Massachusetts thus affords the medically needy aged and disabled far less than the amount the state has determined to

be a subsistence budget for the aged and disabled and which it affords recipients under the SSI program. Because of the discriminatory treatment of the medically needy, they would be much better off if they could forego their Social Security income in order to qualify for SSI and categorical Medicaid coverage. However, both federal and state law preclude this. 42 U.S.C. 1382(e)(2); Massachusetts Public Assistance Policy Manual, Ch. IV, B, p. 4.

The appellee class consists of aged and disabled Social Security recipients in Massachusets who are ineligible because of income for SSI but who have medical expenses, not subject to payment by a third party, which exceed the difference between their income and the SSI eligibility standards. The appellee George Hunter is an example. Mr. Hunter, who is 68 years of age and a double amputee confined to a wheelchair, requires medical attention which (in addition to the amount covered by Medicare) costs several hundred dollars a month. Having worked and paid Social Security taxes for 41 years, he, together with his wife, receives a total of $534.70 in Social Security. This is less than one dollar above the applicable SSI standard. If the Hunters' income was a dollar less, they could retain all of it for their non-medical needs and receive a nominal SSI payment and full Medicaid. However, because of their income, Massachusetts requires them to spend down to $420 in order to receive the Medicaid Mr. Hunter needs.[1] Opinion, at 7a-8a.

On cross-motions for summary judgment, the District Court

---

1 The other named plaintiffs are George and Pearl Hogan. Mr. Hogan has a large surgically-made cavity in his chest as a result of treatment for tuberculosis. He is able to live outside an institution only with daily home nursing care at a cost exceeding $1,000 per month. The Medicaid program requires the Hogans to spend down to more than $100 below the amount they would receive on SSI. Opinion, at 5a-8a. (These figures are in the District Court's findings, which represent the situation as of the time of its opinion. Since the increase in SSI benefits on July 1, 1981, the gap between the SSI and medically needy standards has increased.)

A third couple, George and Celia Beberman, were named plaintiffs below, but since the District Court's decision, Mrs. Beberman has died, and Mr. Beberman has entered a nursing home.

held the Massachusetts Medicaid regulations, Massachusetts Public Assistance Policy Manual, Ch. IV, section B, p. 16, paragraph d, and the four-thirds limitation of Title XIX, 42 U.S.C. 1396b(f) unconstitutional under the Equal Protection requirements of the Fifth and Fourteenth Amendments insofar as they required or applied less favorable income standards to the appellees than the Massachusetts Medicaid program applies to aged and disabled Supplemental Security Income recipients.

THE QUESTION IS NOT SUBSTANTIAL

The Massachusetts Medicaid program applies separate income eligibility standards--one based on the state's estimate of the subsistence needs of the aged and disabled, and one far below that amount--to two groups of aged and disabled people. This is not a case in which a "broad legislative classification" based on "characteristics typical of the affected classes" merely fails to include some "atypical examples." Compare Califano v. Jobst, 434 U.S. 47, 55 (1977), and the cases cited in the Jurisdictional Statement at p. 24. On the contrary, every member of the appellee class is identically situated in terms of the same statutory criteria of age and disability to the class of SSI recipients and has been identified as such by the same bureaucracy which administers the SSI program, the Social Security Administration. And every member of each class is identically situated in terms of the factors regarding income and need which Massachusetts has chosen to apply in its Medicaid program.

It is true that the medically needy have more gross income than SSI recipients, and we do not take issue with the premise of Fullington v. Shea, 320 F. Supp. 500 (D. Col. 1970), aff'd 404 U.S. 963 (1971), on which the appellant relies, that differences in gross income would be sufficient to justify different treatment of applicants in a Medicaid program, such as that involved in Fullington, which did not cover the medically needy. But Massachusetts

has chosen to cover the medically needy, and the premise of the medically needy option is to require consideration of income relative to medical expenses: "[Under the medically needy standard,] the state must be sure that the income of the individual has been measured in terms of both the state's allowance for basic needs and the cost of the medical care he requires."[2] S. Rep. No. 404, reprinted U.S. Code Cong. and Ad. News 89th Cong., 1st Sess. (1965) at 2019. This is precisely what Massachusetts does. It determines Medicaid eligibility for all applicants not in terms of gross income, but in terms of income net of medical expenses. Massachusetts cannot apply different eligibility standards to people identically situated in terms of the factors it has chosen to consider. Califano v. Westcott, 443 U.S. 76 (1979)(arbitrary classification in optional unemployment coverage of AFDC program denies equal protection).[3]

---

2 See 42 C.F.R. 435.831(c): "[In state plans covering the medically needy,][i]f countable income exceeds the income standard, the agency must deduct from income . . . incurred medical expenses. . . ."; Massachusetts Public Assistance Policy Manual, Ch. IV, section B, p. 17, ¶ e.

3 The arbitrariness of the discriminatory standards is exacerbated by the fact that the effective difference between the two classes is that the members of the disfavored class have worked and paid Social Security taxes. The discrimination thus subverts the basic purposes of the Social Security program to provide security against the hazards of disability and old age and to compensate wage earners for contributions made as workers. See Weinberger v. Wiesenfeld, 420 U.S. 636, 645 (1975); Liebman, "The Definition of Disability in Social Security and Supplemental Security Income," 89 Harv. L. Rev. 833, 838-89 (1976). The appellee George Hogan worked and paid Social Security taxes for 24 years and the appellee George Hunter did so for 41 years in the reasonable belief they were accruing rights which would protect them in disability and old age. But the discrimination at issue here has turned their Social Security entitlement into a liability. If they had never worked or paid Social Security taxes, Massachusetts would provide them with what it defines as a subsistence income and Medicaid; because they have worked and paid taxes they cannot receive these benefits. The District Court was fully aware that this result does not itself make the discrimination unconstitutional, but in assessing the rationality of the classification in its statutory context, the Court could appropriately have taken note of the perverse impact of the discrimination on an integrally related program of the Social Security Act. See Weinberger v. Wiesenfeld, supra at 645 (discrmination against women Social Security contributors "more pernicious" than merely sex-based classification because "in this case social security taxes were deducted from [appellee's] salary during the years in which she worked").

The only basis for Massachusetts' discrimination against the appellees is that this discrimination is required by the 1967 amendment to Title XIX which permits a state to determine eligibility of the categorically needy aged and disabled in accordance with its SSI standards but, as a condition of federal reimbursement, limits eligibility standards for the medically needy to four-thirds of the state's AFDC standards. Accordingly, the District Court looked to the context and history of the four-thirds rule in order to determine whether there was a rational basis for the discrimination between appellees and SSI recipients. See Harris v. McRae, 448 U.S. 297 (1980). Applying the most minimal standard of review for which there is any support in the decisions of this Court, it held that there was no rational basis.

A. The Discrimination Is a "Legislative Accident"

Although the District Court considered the hypothetical justifications offered by government counsel for the challenged classifications under the minimum rationality standard, it would have been justified in applying a more demanding standard because it correctly determined that the discrimination against the appellees was a "legislative accident." Opinion, at 19a (quoting Delaware Tribal Business Commission v. Weeks, 430 U.S. 73, 97-98 (1976) (Stevens, J., dissenting)). Earlier this term in Schweiker v. Wilson, _____ U.S. _____, 101 S.Ct. 1074 (1981), the Court sustained a non-suspect SSI classification only after determining that it was "Congress's deliberate, considered choice." Id. at 1083. Though rejecting the conclusion of Justice Powell's dissent, the Court's opinion was fully consistent with its premise that:

> the Court should receive with some skepticism post hoc hypotheses about legislative purpose unsupported by the legislative history. When no indication of legislative purpose appears other than the current position of the Secretary, the Court should require that the classification bear a "fair and substantial relation" to the asserted purpose. Id. at 1088 (Powell, J. dissenting).

The conclusion that the discrimination is a "legislative accident" follows from the facts, clearly shown in the legislative history of the "four-thirds" rule, that: (1) the discrimination became possible only as a remote result of a last minute change in Conference, which was never discussed or debated, designed to remedy an unrelated problem; (2) in enacting the four-thirds maximum, Congress left unchanged a provision of Title XIX which precluded medically needy standards below categorically needy standards; (3) a separate amendment proposed in 1967 which explicitly disfavored the medically needy was severely criticized for doing so and was ultimately rejected.

1. The discrimination at issue here is the inadvertent result of last minute revision in Conference designed to rectify a previously identified eligibility problem peculiar to the categorically needy. This occurred in the following manner: Congress was prompted to consider eligibility limitations in reaction to the New York Medicaid program,[4] which set its eligibility standards "in or close to an average income range." H. Rep. No. 544, 90th Cong., 1st Sess. (1967), at 117. The New York Department of Social Welfare had calculated that the New York standards made 45 percent of the entire state eligible for Medicaid, R. Stevens and R. Stevens, Welfare Medicine in America 92 (1974); testimony before the Ways and Means Committee put the estimate at between 40 and 45 percent statewide and as high as 70 percent in some counties. President's Proposal for Revision of the Social Security System: Hearings on H. R. 5710 Before the House Committee on Ways and Means, 90th Cong., 1st Sess., 603, 1953 (1967).

---

4 See e.g., 113 Cong. Rec. 23124 (Remarks of Rep. Robison)("It was the New York plan that precipitated committee action in this respect"); id. at 23084 (Remarks of Rep. Hanley)("The State of New York . . . moved quickly to show us the error of our ways"); id. at 22783 (Remarks of Rep. Quillen)("the Medicaid act (. . .) is amended to remove the problem pointed up last year by the events in New York"); id. at 33168 (Remarks of Sen. Javits)("efforts of Congress to correct what New York did").

Three versions of the income eligibility limitation were introduced and considered. In the course of the testimony in the Senate, Undersecretary of Health, Education and Welfare Wilbur Cohen pointed out a problem with the House Ways and Means Committee version of the income limit. The Ways and Means income maximum was 133 1/3 percent of the "highest amount ordinarily paid" to recipients under a state's AFDC program. Undersecretary Cohen considered this language important because some states--he mentioned Indiana and Texas--pay recipients only a fraction of the difference between their countable income and the AFDC eligibility or "need" standards. Because in these states the payment standards are below the need standards, a person can have countable income in excess of the "highest amount ordinarily paid" and still be eligible to receive some payment (i.e., a payment of some fraction of the difference between income and the need standard). In a few states the gap between the AFDC maximum payment and the AFDC need standards was so great that a Medicaid maximum of 133 1/3 percent of the maximum payment would be less than the AFDC need standards and hence would exclude some AFDC recipients.[5] Undersecretary Cohen thought this result a "drafting oversight." Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Committee on Finance, 90th Cong., 1st Sess. 280-82 (1967).

Undersecretary Cohen's point was taken up by others in testimony and in debate; his examples were repeated, and Mississippi and Ohio were also given as examples of states in which the Ways

---

5 For example: A state might have an eligibility or need standard of $200 for a two-person family but pay only 50 percent of "need." The highest amount paid would be $100. A two-person family with $150 countable income would be $50 below the need standard and, in some states, would receive 50 percent of the deficiency, or $25. If Medicaid eligibility were limited to 133 1/3 of the AFDC payment standard, such a family, though eligible for an AFDC payment (thus categorically needy), would be ineligible for Medicaid because his income ($150), though below the need standard, would be above 133 1/3 percent of the highest amount paid ($133.33). See Rosado v. Wyman, 397 U.S. 397, 408-09 (1970); Jefferson v. Hackney, 406 U.S. 535, 539-46 (1972).

and Means version would exclude some of the categorically needy. See id. at 784, 1442, 1684 (Statements of Senator Robert Kennedy; George Meany, and Walter Reuther). Although these remarks demonstrate awareness that the Ways and Means version might require Medicaid eligibility standards below cash assistance need standards (the "below need" problem), none of them shows any awareness that it might require medically needy standards below the categorically needy Medicaid standards (the "discrimination" problem). For one thing, the problem arising from low AFDC payment ratios was distinctive to states with less generous assistance programs, which were unlikely to cover the medically needy in their Medicaid programs. None of the four states discussed as examples where the "below need" problem would occur had then or has today Medicaid programs covering the medically needy. S. Rep. No. 744, 90th Cong., 1st Sess. 178 (1967); CCH Medicare and Medicaid Guide ¶¶ 15,584, 15,604, 15,626, 15,644. More fundamentally, up to the time of the Conference Report there could have been no awareness of the "discrimination" problem because this problem did not exist under any of the versions of the income limitation considered up to that point. All these versions applied equally to the categorically and medically needy. Under any of them, if a state where the "below need" problem occurred had covered the medically needy, the income maximum would have required both the categorically and medically needy to spend down below the cash assistance levels.

The discrimination which the appellees challenge only became possible when the Conference Committee accepted the House version but altered it to except the categorically needy. Conf. Comm. Rep. No. 1030, reprinted U.S. Code Cong. and Ad. News, 90th Cong., 1st Sess., 3209 (1967). This change was merely intended to remedy the "below need" problem identified by Undersecretary Cohen, et al. It was never explained or discussed in either the Conference

Report or in floor debate.[6] The Conference bill, part of an Omnibus Social Security bill with major changes in many programs, was considered under a closed rule with minimal debate and passed.[7]

Far from showing awareness of the possibility of discrimination created by the Conference change, the remarks of Senators Kennedy and Mondale on which the Jurisdictional Statement relies at p. 20 indicate that at the time of passage these Senators were not even aware that the change had been made, much less of the consequences it made possible. Senator Kennedy began by stating that "the House Medicaid limitation has been adopted," without saying anything about the change made in the House version by the Conference Committee to except the categorically needy. He then argued against the limitation, stating that it would require eligibility levels in Mississippi as low as $80 a month and in Ohio as low as $3,000 a year. 113 Cong. Rec. 36784 (1967). Senator Mondale, also referring to "the House bill" without any mention of the change, quoted Undersecretary Cohen's testimony concerning the "below need" effects on eligibility levels in Indiana and Texas. Id. at 36819. These are the states and the figures discussed previously in testimony about the "below need" problem. Thus, Senators Kennedy and Mondale--the only Congressmen to discuss the four-thirds rule in any detail after conference--were not even aware that the Ways and Means version had been modified in conference to except the categorically needy and thus to eliminate the par-

---

6 Although solutions to the "below need" problem involving raising the maximum were proposed in debate prior to Conference, e.g., 113 Cong. Rec. 32845-46 (1967)(Remarks of Sen. Kuchel), insofar as we have been able to discover, the solution adopted in Conference--excepting the categorically needy from the four-thirds maximum--was not proposed or discussed prior to Conference.

7 See 113 Cong. Rec. 23129 (Aug. 7, 1967)(Remarks of Rep Mathias): "The House has had less than two weeks to consider the Committee's proposals and in this short time has not been able to make a full assessment of their impact nationally or in individual cities and states"); id. at 3678+ (Dec. 15, 1967)(complaint by Sen. Kennedy on passage of Conference bill that there was little time to consider).

ticular "below need" problem they were talking about. And since this was the change which made possible discrimination against the medically needy, they could not have been aware of that possibility.

There would be no reason to expect even a Congressman who was aware of the Conference Committee change to be aware of the discrimination problem it had created. Even after the change, the discrimination could occur only in a state which covered the medically needy and in which the gap between the AFDC and old age and disability assistance levels was such that four-thirds of the former would be less than the latter. The change which made the discrimination possible was a last minute response to a problem which had been identified and discussed entirely in terms of the categorically needy and in terms of the programs of states which did not (and still do not) cover the medically needy. And in the only state whose medically needy levels were extensively discussed--New York--the 133 1/3 percent of the AFDC standards was not less than the old age standards.[8]

The discrimination problem has materialzed largely because in the course of the inflation of the years since 1967 the gap between AFDC and old age and disability (SSI) standards has widened. In 1976, Congress provided for automatic increases in the SSI standards in accordance with increases in the cost of living. 42 U.S.C. 1382(f). By contrast, AFDC benefits have not

---

8 Indeed, it appears that at the time of the 1967 amendments there were only two states with plans covering the medically needy in which the four-thirds maximum would be less than the old age standards.

The only information relevant to this issue in the legislative history is a table at page 178 of the Senate Report. The table compares for each state what the maximum for one person would be under the Ways and Means version (133 1/3 of AFDC) and under the Senate version (150% of Old Age). If one deducts one-third from the Old Age figure to get 100% of the Old Age figure and then compares this with the four-thirds figure, it appears that of the 22 states with programs covering the medically needy, only in California and Nebraska was the four-thirds maximum below the old age standard. (There is also a column showing the comparisons for four-person families, but since the aged and disabled can apply only as individuals or couples, this information is not useful.)

not been indexed and have increased more slowly than SSI. See Urban Systems Research and Engineering, AFDC Standards of Need (Study prepared for Office of Research and Statistics, Social Security Administration (1980)). In consequence, there are now about 11 states in which the four-thirds maximum is below the cash assistance standards for the aged and disabled.

The argument in the Jurisdictional Statement that Congress was aware of the discrimination challenged here is based on confusion of the "below need" issue with the "discrimination" issue.[9]

---

9 However, one remark which refers to neither problem is inaccurately set out in the Jurisdictional Statement so as to make it appear to refer to the "discrimination" problem." The remark appears as follows at p. 16 of the Jurisdictional Statement.

> Under the proposed Title XIX income limitation we have people drawing old age security benefits [OASDI]--whose income [after deduction of medical expenses] is less than some drawing old-age assistance, and they will be precluded--under the clear language of this bill--from getting equivalent medical care that is received by their better-off counterparts on OAA [now SSI]. I do not think that is thoughtful legislative product." 113 Cong. Rec. 23092 (1967)(Remark of Congressman Burton, as quoted, J.S. at 16).

Because of the bracketed language "after deduction of medical expenses" inserted by the Secretary, Congressman Burton's remark appears to refer to the possibility of discrimination against the medically needy. However, as noted above, the income limitation in the bill he was referring to--the House Ways and Means version --did not distinguish between categorically and medically needy and could not have caused discrimination against the latter. The sentence which precedes the quoted passage in the Congressional Record makes clear that the Secretary's interpolation is misleading. Congressman Burton was not referring to the medically needy:

> What if one is too proud to take welfare and the combined social security benefits between husband and wife are a lesser amount that than which they would receive on social security? Id.

Plainly, Congressman Burton was not referring to the possibility that the medically needy would have to spend down below the categorically needy levels. He was referring to the problem of people with incomes below the cash assistance standards, who would therefore be eligible for cash assistance and categorically needy coverage, but who were "too proud" to apply for it. (Congressman Burton seems to have thought that the House bill would have required someone eligible for cash assistance to accept it in order to receive Medicaid; this was incorrect. Whatever the meaning of this statement, accurately quoted, it does not refer to the medically needy, and it could not have referred to the discrimination problem.)

The appellees are the victims of both problems, but their constitutional claim arises from the latter. The legislative history on which the Secretary relies deals only with the "below need" problem, and this history only further confirms Congress's unawareness of the effects of the four-thirds rule involved in this case. For in the one context in which Congress identified the "below need" problem--the categorical programs of a few states with low AFDC payment ratios--its response was to attempt to eliminate the problem.

2. When first enacted in 1965, Title XIX contained two comparability requirements. The first requires that the medically needy income standards be "comparable" to the categorically needy income standards. 42 U.S.C. 1396a(a)(17).[10] There can be no dispute that this provision was originally intended to prevent a state from setting medically needy standards below the corresponding categorically needy standards.[11] The federal courts have repeatedly held such discrimination to violate the requirement,[12] and the

---

10 The income comparability requirement also appeared at Section 1396a(a)(10) prior to the amendments to Title XIX enacted this month as part of the Omnibus Reconciliation Act of 1981. Pub. L. 97-35, Section 2173, 97th Cong., 1st Sess. (1981). Subparagraph (a)(10), as amended, does not retain the additional comparability language, but the requirement still appears at sub-paragraph (a)(17). The legislative history is explicit that no change in the comparability requirement was intended. 127 Cong. Rec. 5813 (July 31, 1981)(Remarks of subconference co-chairman Rep. Dingell); id. at 5804 (Remarks of Rep. Waxman).

11 See S. Rep. No. 404, 89th Cong., 1st Sess. 79 (1965):

> In no event, however, with respect to either [the medically needy spend down] provision or that described below with respect to the use of deductibles for certain items of medical service, may a state require the use of income and resources which would bring the individual's income below the amount established as a test of eligibility under the state plan. Such action would reduce the individual below the level determined by the state as necessary for his maintenance.

12 Aitchison v. Berger, 404 F. Supp. 1137 (S.D.N.Y. 1975), aff'd 538 F.2d 307 (2d Cir.), cert. denied 429 U.S. 890 (1976); Brown v. Beal, 404 F. Supp. 770 (E.D. Pa. 1975); see also Caldwell v. Blum, 621 F.2d 491 (2d Cir. 1980), cert. denied, 49 L.W. 3894 (1981); Schaak v. Schmidt, 344 F. Supp. 99 (E.D. Wis. 1971). The constitutionality of the four-thirds rule was not at issue in these cases because in all of them comparability could be achieved without exceeding the four-thirds maximum.

Secretary himself so interprets it except where the categorical standards are above the four-thirds maximum. 42 C.F.R. 435.812-14. The second comparability requirement required that the medical services provided to different categorically needy groups be "similar in amount, duration and scope"; in effect, it required that AFDC recipients be afforded the same services as the aged and disabled categorically needy.[13]

In the course of the 1967 amendments, Congress made no change in the provision requiring comparability of income standards. By contrast, in connection with a provision of the 1967 amendments which was perceived as modifying the requirement of comparable services, it amended the comparable services provision to make an explicit exception. All versions of the 1967 amendments contained the Medicaid "buy in" provisions, which now appear at 42 U.S.C. §§ 1395v and 1396b(b)(1), making it possible for Medicaid programs to purchase Medicare coverage for the aged and disabled and denying federal reimbursement for Medicaid expenditures which would have been unnecessary if Medicare coverage had been purchased. Both houses perceived the "buy-in" provisions as altering the comparability of service requirement. Since only the aged (and since 1972, the disabled) are eligible for Medicare, a Medicaid program could not purchase Medicare coverage for the non-aged and non-disabled, and it could not provide comparable services for them unless it expanded Medicaid coverage beyond the requirements of Title XIX. In striking contrast to the history of the four-thirds limit, Congress consistently acknowledged throughout the legislative history that the "buy-in" provision would modify the comparability requirement for services, and in all versions of the bill

---

13 This second comparability requirement appeared in Section 1902(a)(10)(c)(42 U.S.C. 1396a(a)(10)(c)); it was not retained in the Medicaid amendments of the Omnibus Reconciliation Act of 1981. Pub. L. 97-35, section 2175, 97th Cong., 1st Sess. (1981).

it amended that provision to expressly except Medicare coverage purchased for the aged from the requirement that comparable services be provided AFDC recipients. See 42 U.S.C. § 1396a(a)(10)(II)(West 1974).

The exception appeared in the House version (H.R. 10208) and the enacted bill (Pub. L. 90-248) as section 223(a) under the heading "Modification of Comparability Provisions." This was the only express change made in the comparability provisions. The "Modification of Comparability Provisions" section thus indicated that the Medicare "buy-in" section was the only provision in the bill which affected the comparability requirements of Title XIX. The inference is inescapable that, had the legislators been aware that the four-thirds rule would modify the provision requiring comparability of income standards between the categorically and the medically needy, they would have specified this intention under the "Modification of Comparability Provisions" heading.[14]

3. In contrast to the four-thirds rule, a provision of the Senate bill which was designed to disfavor the medically needy was explicitly identified as doing so and was eliminated from the bill as enacted. The Senate bill was designed to reduce federal Medicaid expenditures in two ways. One was by the limit on state income eligibility standards (150 percent of the Old Age standards); like the Ways and Means four-thirds rule, this provision did not distinguish between the categorically and the medically needy.

---

14 The inference is reinforced when the "comparability" provision is considered in the light of the Congressional response to the "below need" problem in 1967. In 1965, Congress recognized the possibility that a medically needy person might be required to spend down "below the level determined by the state as necessary for his maintenance." S. Rep. No. 404, 89th Cong., 1st Sess. 79 (1965), and acted to prohibit it. In 1967, when it was pointed out that the Ways and Means bill would require some AFDC families in a few states to spend down below the need level, it acted again to prohibit this. See pp. 11-15, supra. Thus, Congress has consistently regarded the "below need" problem as signficant and undesirable. Its failure to even mention the problem in the context which it arises in this case could only be due to inadvertence.

The second was a reduction in the percentage rate at which the federal government would reimburse state Medicaid expenditures; this provision explicitly applied only to the medically needy. In debate, Senator Javits criticized the reimbursement rate provision on the ground that it discriminated against the medically needy, and it was eliminated from the enacted bill.

The treatment of this episode in the Jurisdictional Statement at pp. 19-20 is misleading. The Secretary states that Senator Kuchel offered an amendment increasing the income standard maximum and then implies that Senator Javits' remarks about discrimination were made in support of the Kuchel version of the income maximum and against the Finance Committee income maximum. In fact, however, Senator Kuchel's amendment contained two provisions, the one raising the income eligibility maximum and a "far more important" provision eliminating the discriminatory reimbursement percentage provision of the Senate bill. 113 Cong. Rec. 33167 (Nov. 20, 1967). It is clear from the context that the remarks of Senators Javits and Long about discrimination refer to the subsequently eliminated reimbursement provision, not to the income standard maximum.[15] Indeed, these remarks could not have referred to the income standard maximum because the Senate bill did not at that point distinguish between medically and categorically needy. The remarks thus show no recognition of the possibility that discrimi-

---

15 See, e.g.: "MR. JAVITS: . . . I understand the problem in the [Finance] Committee. They included a 150 percent standard on old-age assistance.

"The House passed a lower ceiling. The Senate Committee reported a bill with a higher ceiling, but took away its positive effect with only 25 percent Federal matching funds, thereby discriminating against those who might be medically indigent.

. . .

"MR. LONG OF LOUISIANA: The committee bill encourages the State to concentrate its medical assistance for those who are most in need, those who qualify for public welfare assistance. We would continue to match with regard to those who do not qualify for public assistance. As to them, however, we would not be as liberal." 113 Cong. Rec. 22170-71 (Nov. 20, 1967). (Emphasis added.)

nation might result from any of the income eligibility maxima. By contrast, the history of the Senate reimbursement provision shows that where Congress did perceive discrimination it acted to eliminate it.

B. The Discrimination Is Not Rationally Related to the Purposes Hypothesized by Government Counsel.

Although the District Court would have been justified in applying a higher standard than minimum rationality to a discrimination resulting from a "legislative accident," Schweiker v. Wilson, supra, it declined to do so. Opinion, at 9a-10a. Its decision rests not merely on the absence of any actual legislative purpose, but on the failure of the government counsel to suggest even a hypothetical goal which in "the context and history" of the statute could "serve as a basis for judging whether the statutory distinction . . . rationally serves a valid legislative purpose." Weinberger v. Wiesenfeld, 420 U.S. 636, 655 (1975)(Rehnquist, J., concurring).

The Secretary could suggest only two purposes, which he has repeated in the Jurisdictional Statement. The first purpose is "to reduce federal expenditures." J.S. at 25. However, it is axiomatic in the review of welfare classifications that the government "must do more than claim that denying aid to qualified persons saves money." Medora v. Colautti, 602 F.2d 1149, 1154 (3rd Cir. 1979). Rather, it must show that the specific "classifying feature" of the provision is a rational means of doing so. Rinaldi v. Yeager, 384 U.S. 305, 309 (1969); Shapiro v. Thompson, 349 U.S. 618, 633 (1969); Doe v. Plyler, 628 F.2d 448, 459 (5th Cir. 1980). Since "[o]bviously any measure that cuts financial benefits . . . conserves state funds," to accept such a rationalization would be tantamount to holding that equal protection requirements do not apply in welfare programs. Morales v. Minter, 393 F. Supp. 88, 100 (D. Mass. 1975). Accordingly, this Court has

invariably required the showing of a more definite basis than conserving funds in the review of welfare classifications. E.g., Schweiker v. Wilson, 101 S.Ct. at 1084; U.S. Railroad Retirement Board v. Fritz, 101 S.Ct. at 460.

The only other justification hypothesized by the Secretary is to "encourage those who generally are in a better position to do so to purchase private insurance or, in the case of most if not all of the appellees, to obtain optional Medicare coverage." J.S. at 25-26. The briefest acquaintance with the legislative history and structure of the Medicaid program makes clear that this justification is without merit.

With respect to Medicare, it is without merit because neither Congress nor the states have any need to "encourage" any applicant to purchase Medicare. In the course of the 1967 amendments to the Social Security Act, Congress did express concern that Medicaid might discourage the aged from purchasing Supplementary Medical Insurance Medicare coverage. H. Rep. No. 544, 90th Cong., 1st Sess. 118 (1967). However, it dealt with that concern, not through the limitation on eligibility standards, but through the "buy-in" amendments permitting states to purchase Medicare coverage for eligible Medicaid recipients and denying federal reimbursement for Medicaid expenditures which would have been unnecessary if such coverage had been purchased. 42 U.S.C. 1395v, 1396b(b)(1), as amended Pub.L. 96-499, section 945(e)(1980). Moreover, since the state must deduct the cost of Medicare premiums from an applicant's income in determining eligibility, 42 C.F.R. 435.831(c)(i), the medically needy program does not create incentives to decline optional Medicare.[16] Nevertheless, to the extent that applicants

---

16 All Social Security recipients over 65 and all recipients disabled for more than 24 months are eligible for both Medicare Hospital Insurnace and Medicare Supplementary Medical Insurance. 42 U.S.C. 1395c, 1395o. An eligible person automatically receives both types of insurance. Hospital insurance is without charge;

(footnote continued next page)

do not have coverage a state can solve this problem with the remedy Congress provided: the "buy-in."

A similar arrangement integrates private insurance for applicants and recipients who have it. Premiums are credited against income in determining eligibility, and the state does not pay for expenses covered by private insurance. Id.

The situation with respect to private insurance does differ from that with respect to Medicare in that the Act does not provide for state purchase of private insurance for applicants and recipients. However, Congress did not intend to disfavor people in the situation of the appellees because they are "better able to provide for themselves . . . by purchasing private health insurance," J.S. at 22, nor would it have been rational for Congress to have done so. First, since Congress never contemplated that the four-thirds rule would require the medically needy aged and disabled to spend down below the cash assistance levels, it obviously had no occasion to consider whether aged and disabled people with higher gross income but less income net of medical expenses than cash assistance recipients could better afford insurance. See pp. 11-16, supra. Second, Congress's concerns about private insurance did not include the aged and disabled at all. The only mention of the aged and disabled in the context of insurance focused on optional Medicare insurance, which Congress addressed through the Medicare "buy-in" provisions. Moreover, although Congress had no evidence before it in 1967 on the availability of medical insurance to the aged and disabled, it had been presented with extensive

---

16 (con't) Supplementary Medical Insurance requires a monthly premium, currently $11, which is deducted from the Social Security payment. Since the 1972 amendments providing for automatic enrollment, Supplementary Medical Insurance has been "optional" only in the sense that a recipient may "opt out" by affirmatively declining coverage. 42 U.S.C. 1395p(f); 42 C.F.R. 405.210. (Having done so, however, he can re-enroll at any time. Pub.L. 96-499, section 945(a)(1980).)

evidence in connection with the original enactment of Medicare and Medicaid showing that the vast majority of the aged and disabled are unable to obtain adequate insurance. Blue Cross and Other Private Health Insurance for the Elderly: Hearings Before the Subcommittee on Health of the Elderly of the Senate, 89th Cong., 2d Sess. 3-13, 47-54 (1964); Medical Care for the Aged: Hearings Before the Committee on Ways and Means, 89th Cong., 1st Sess. 36-43 (1965). Third, the concern expressed with respect to private insurance was that Medicaid not "supplant health insurance . . . for individuals and families in or close to an average income range." H. Rep. No. 544, supra at 118 (emphasis added). As shown above, Congress was responding to the New York program which made 40 to 45 percent of the state eligible. See pp. 11, supra. Moreover, on the page following the quoted language, the House Report specifically emphasizes that the income maximum was not intended to change the principle that in programs covering the medically needy "a family's income is first reduced by the amount of their medical expenses in determining eligibility." Id. at 119. The assumption that people "in or close to an average income range" are better able to get adequate insurance than those on public assistance says nothing about the availability of insurance to people whose income net of medical expenses is far below the state-defined subsistence level.[17]

---

17 The Jurisdictional Statement argues at p. 22, n. 32 that, because Congress could rationally have concluded that some middle income people are better able to afford insurance, the appellees' claims amount to merely a matter of "overbreadth." The argument makes sense only if one accepts the premise that the relevant disfavored class is not the class constituted by the appellees but the class of all non-recipients of AFDC or SSI. Of course many equal protection claims could be reduced to a matter of "overbreadth" if the state were permitted to define the disfavored class as all those not benefitted by the distinction. Such a tactic misses the entire point of the claim, however, which is not simply that the statute disfavors the claimants, but that the claimants are similarly situated to the favored class in terms of the factors which the statute itself makes relevant. See Weinberger v. Wiesenfeld, 420 U.S. 636, 648-53 (1980); Califano v. Boles, 443 U.S. 282, 293-96 (1979)(favored and disfavored classes defined in terms of statutory purposes).

Finally, even if the Secretary's suggestion is considered as a speculative hypothetical justification, it could not satisfy minimal rationality. First, there is no reason to think the appellees are "better able" to afford private insurance. The cost of insurance is most fundamentally a function of the magnitude and probability of the risk insured against. See, e.g., H. Denenberg, et al., Risk and Insurance 509 (3rd ed. 1974). In the case of health insurance, the risk insured against is medical expenses. Id. at ch. 21. The relatively high susceptibility of the aged and disabled to medical expenses is, of course, the major reason why they are unable to obtain adequate private insurance. See Blue Cross and Other Private Health Insurance for the Elderly, supra; Medical Care for Aged, supra. Even if one is willing to speculate seriously on which of two such vulnerable and impoverished groups as SSI recipients and the appellees have better access to private insurance, one would have to conclude that SSI recipients are at least as likely to have better access because the appellees are more likely to be in poor health and have medical expenses. One can receive SSI without having any medical expenses, and undoubtedly some, perhaps many, SSI recipients have none. By contrast, each member of the appellee class has medical expenses of at least the amount of the difference between his or her income and the SSI income standard.

Second, even if the appellees were "better able" to secure private insurance, it would be rational to "encourage" them to purchase it only if such insurance would reduce Medicaid expenditures. Since insurance premiums are credited against income in determining Medicaid eligibility, 42 C.F.R. 435.831(c), Medicaid expenditures would be reduced only if the benefits received from the insurance for services for which Medicaid would otherwise have to pay exceeded the premium cost of the insurance. The data that Congress has so far considered on private insurance for the aged

make it far more probable that the opposite is the case. These data indicate that such private insurance as is available to the aged (and presumably, a fortiori, the disabled) tends to provide benefits far below premium cost, to provide worthless duplicative coverage, to exclude many of the most important and expensive services covered by Medicaid (e.g., prescription drugs, nursing home care), and to deny much of the most urgently needed coverage through exclusions for "pre-existing conditions." To encourage the purchase of such insurance would not be a rational way of reducing Medicaid expenditures. On the contrary, it would increase Medicaid expenditures. See Blue Cross and Other Private Health Insurance for the Elderly, supra at 3-13, 47-54; Medical Care for the Aged, supra at 36-43; Senate Sepcial Committee on Aging, Private Health Insurance Supplementary to Medicare (Committee Print 1974); see also Reed and Myers, "Health Insurance Coverage Complementary to Medicare," 30 Social Security Bulletin 3 (August 1967). The Secretary's speculation is thus contrary to the thrust of Congress's consideration of the subject. More fundamentally, in the absence of either a legislative judgment or some factual support of which the Court can take notice--and the Secretary has cited none--the Secretary's speculation cannot provide a rational basis for the discrimination even under the most limited standard for which there is any support in this Court's decisions.

CONCLUSION

Because this is an unusual case in which the challenged discrimination is a "legislative accident," the appellee's equal protection claim poses no risk of judicial encroachment on the legislative province. On the contrary, the District Court's decision refuses no deference to the legislature; it merely performs the marginal, complementary role of rectifying an egregiously arbitrary legislative oversight. Moreover, even under a more restrictive conception of the Court's role which would require it to up-

hold the statute upon a purely hypothetical rational basis, the decision is correct because the discrimination against the appellees is not rationally related even to the hypothetical purposes suggested by the Secretary.

Accordingly, the decision of the District Court should be affirmed.

Respectfully submitted,

William H. Simon
Stanford Law School
Stanford, California 94305

Gary Bellow
Legal Services Institute
3529 Washington Street
Jamaica Plain, Massachusetts

Mark Coven
Greater Boston Elderly Legal Services
106 Norway Street
Boston, Massachusetts

Gill Deford
National Senior Citizens Law Center
1636 N. 8th Street
Los Angeles, California 90017

Appellant's Reply Brief

Office - Supreme Court, U.S.
FILED
OCT 8 1982
CLERK

No. 81-213

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

REPLY BRIEF FOR THE APPELLANT

REX E. LEE
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

TABLE OF AUTHORITIES

Cases:	Page
Fullington v. *Shea*, 404 U.S. 963, aff'g 320 F. Supp. 500	10
Jefferson v. *Hackney*, 406 U.S. 535	9
Statutes:	
Social Security Act, Title XIX, 42 U.S.C. (& Supp. III) 1396 *et seq.*:	
Section 1902(a)(10)(A), 42 U.S.C. 1396a(a)(10)(A)	6
Section 1902(a)(13), 42 U.S.C. (& Supp. III) 1396a(a)(13)	8
Section 1903(f), 42 U.S.C. 1396b(f)	3, 7
Pub. L. No. 90-248, Section 220, 81 Stat. 898-899	4
Miscellaneous:	
Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. (1967)	5

In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-213

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

REPLY BRIEF FOR THE APPELLANT

1. Appellees concede (Mot. to Aff. 12) that Congress adopted the 133⅓% AFDC-payment income limitation, which by its terms is applicable to the medically needy and not to the categorically needy, with full awareness that in some cases the limitation would require Medicaid applicants to spend down to a point below the standards of need established for the categorically needy. Indeed, appellees argue that Congress *only* focused on the so-called "below need" problem and, therefore, was completely unaware of what appellees call the "discrimination" problem.[1] Like the district court, however, appellees

[1] Appellees define the "below need" problem as "Medicaid eligibility standards below cash assistance need standards"

offer no explanation as to how Congress could have focused on the fact that 133⅓% of the AFDC payment standard was lower than the categorical assistance standards in some states and then overlooked that fact when it made the standard applicable only to the medically needy. As we have already pointed out (J.S. 17-18 n.25), there is no such explanation.[2]

(Mot. to Aff. 12) and the "discrimination" problem as "medically needy standards below the categorically needy Medicaid standards" (*ibid.*). While the Act distinguishes between the medically needy and the categorically needy, and, in one sense, the medically needy are treated less favorably than the categorically needy, we submit that the Act does not "discriminate" against the medically needy in any meaningful sense. Rather, the Act treats different groups differently. Contrary to appellees' repeated assertion that they and the categorically needy are identically situated with respect to the "factors which the statute * * * makes relevant" (Mot. to Aff. 23 n.17; see *id.* at 7, 8), appellees and the categorically needy are not identically situated with respect to the only factor that is relevant in this case, *i.e.*, the amount of gross income and consequent ability to provide for their own medical expenses.

[2] Appellees assert (Mot. to Aff. 14) that "[t]he discrimination problem has materialized largely because in the course of the inflation of the years since 1967 the gap between AFDC and old age and disability (SSI) standards has widened." This assertion underscores the obvious artificiality of the purported distinction between the "below need" problem and the "discrimination" problem in this context. The discrimination of which appellees complain "materialized" in 1967, when Congress adopted the 133⅓% AFDC payment limitation *and* made it applicable to the medically needy but not to the categorically needy. Appellees concede (Mot. to Aff. 14 n.8) that the 133⅓% limitation has always required, in some states, that the medically needy incur medical expenses that could reduce their income to an amount less than categorical assistance standards. Of the 22 states that had medically needy programs in January 1967, 133⅓% of the AFDC payment amount for

The legislative history of Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) makes manifest what is apparent from the language of the provision. Nevertheless, appellees contend that the "discrimination" against the medically needy prescribed by the provision must have been the result of a legislative accident. According to appellees (Mot. to Aff. 20), "the history of the Senate reimbursement provision [which "was designed to disfavor the medically needy" (*id.* at 18)] shows that where Congress did perceive discrimination it acted to eliminate it." Appellees apparently contend that since the Senate provision was not ultimately enacted, Congress must not have intended to "discriminate" against the medically needy in any respect. But the Senate provision was not enacted because the provision at issue in this case, which also was "designed to disfavor the medically needy," was enacted in its place. Furthermore, as we have explained (J.S. 19-20), the Senate flatly rejected the policy argument that it was improper to "discrimi-

---

one person was less than the Old Age Assistance standard in six of them and, therefore, resulted in a medically needy income limitation that was below the Old Age Assistance standard. App. A, *infra*.

In the other 15 states that had Medicaid programs in 1967, 133⅓% of the AFDC payment amount in 11 of them would have been less than the Old Age Assistance standard. App. A, *infra*. Finally, in the 14 jurisdictions that did not have Medicaid programs in 1967, 133⅓% of the AFDC payment amount in 11 of them would have been below the Old Age Assistance standard. *Ibid.* That these 22 states did not have programs covering the medically needy in 1967 is immaterial since the 133⅓% limitation would govern whenever they chose to adopt such programs. Congress was clearly concerned about the nationwide impact of the various income-limitation proposals.

nate" against the medically needy when it rejected the Kuchel Amendment, which (as appellees agree) was specifically intended to eliminate discrimination against the medically needy.[3]

During the Senate debate on the Conference Report, Senator Kennedy and Senator Mondale pointed out that in some states 133⅓% of the AFDC payment amount would be less than the standard of need for categorical assistance. Although, as amended in conference, the 133⅓% limitation only applied to the medically needy, appellees assert (Mot. to Aff. 13-14) that Senators Kennedy and Mondale criticized the provision only because of its impact on the categorically needy.[4] Appellees support this assertion

---

[3] Appellees also attempt to support their "legislative accident" thesis with the remarkable assertion that Congress' failure to include the 133⅓% income limitation, which expressly establishes different eligibility standards for the medically needy and the categorically needy, in the section of the bill headed "Modification of Comparability Provisions" implies that the legislators were either unaware that the provision established different income standards for the medically needy and the categorically needy or that they did not intend to establish different income standards. Section 220 of Pub. L. No. 90-248, 81 Stat. 898-899, which established the 133⅓% limitation, is headed "Limitation on Federal Participation in Medical Assistance." Congress' decision to label a provision that limits federal reimbursement of Medicaid expenditures as a limitation on federal participation hardly suggests, and certainly does not support, appellees' assertion.

[4] As to Senator Kennedy, this assertion is particularly untenable. During the Senate hearings on the House bill, Senator Kennedy specifically observed that the 133⅓% AFDC payment standard would result in *medically needy income standards* that were below the standards of need established for the categorically needy, and he complained that such a result was contrary to the intent of the Congress that enacted the Medicaid statute:

with the further assertion that (*ibid.*) "these Senators were not even aware that the change had been made, much less of the consequences it made possible." Indeed, according to appellees (*id.* at 14), "[t]here would be no reason to expect even a Congressman who was aware of the Conference Committee change to be aware of the discrimination problem it had created." Yet, as noted above, appellees offer no explanation as to how anyone could have been aware that 133⅓% of the AFDC payment standard was in some states less than the categorical assistance standard and fail to realize that a provision that imposed the 133⅓% standard on the medically needy but not the categorically needy created a "discrimination" problem.[5]

> [I]nstead of looking to a State's definition of minimum need, [the House bill] looks to the amount which the State actually pays its public assistance recipients. *Title XIX intended that medical indigency be defined at a level substantially in excess of a State's public assistance definition of minimum need. The House bill will in many States have the opposite effect,* and is therefore, totally unrealistic.

Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess., Pt. 2, 784 (1967) (emphasis added). Senator Kennedy cited Mississippi and Ohio as examples of states in which this would occur. *Ibid.* See also *id.*, Pt. 1, at 280 (statement of Wilbur Cohen) ("[T]he House limitation will destroy the concept of medical indigence in a number of States."); *id.*, Pt. 3, at 1684 (statement of Walter Reuther) ("With the ceiling of 133⅓% of the AFDC assistance payment level ultimately to be established by H.R. 12080, the 'medically needy' all but disappear.").

[5] Appellees adopt a similar approach with respect to Representative Burton's comments (J.S. 16), positing (Mot. to Aff. 15 n.9) that Representative Burton incorrectly thought that

2. Appellees contend that Congress' desire to reduce Medicaid expenditures and to encourage those persons who are generally in a better position than the categorically needy to purchase private insurance to do so (or, in the case of most if not all of the ap-

---

"the House bill would have required someone eligible for cash assistance to accept it in order to receive Medicaid." As we have pointed out (J.S. 15 n.23), although the House provision did not expressly distinguish between the medically needy and the categorically needy, it did not amend Section 1902 (a) (10) (A) of the Social Security Act (42 U.S.C. 1396a (a) (10) (A)), which required all participating states to provide Medicaid benefits to all persons *"receiving"* cash assistance. The failure to amend Section 1902 (a) (10) (A) suggests that the 133⅓% income limitation was not intended to exclude any of the categorically needy. In any event, when Representative Burton's remarks are read in context, it seems reasonably clear that he assumed that the categorically needy would not be denied Medicaid benefits because of the income limitations prescribed in the House bill. See App. B, *infra*.

The "clear language" of the "proposed Title XIX limitation" that Representative Burton opposed only "precluded" Medicaid benefits for those OASDI benefit recipients whose income after deduction of medical expenses was greater than 133⅓% of the applicable AFDC payment amount. Only if the OASDI benefit recipient's income *after deduction of medical expenses* was less than the OAA assistance payment but greater than 133⅓% of the AFDC payment amount could the situation described by Representative Burton occur. Only then would the proposed limitation preclude the OASDI recipient from receiving Medicaid benefits that his "better off" OAA counterpart received by virtue of Section 1902 (a) (10) (A). The OASDI benefit recipient who was "too proud" to accept OAA benefits could qualify as medically needy, if after deduction of medical expenses his income was less than 133⅓% of the AFDC payment standard. Representative Burton, of course, was from California, one of the two states in which appellees concede that 133⅓% of the AFDC payment amount was lower than the Old Age Assistance standard of need in January 1967.

pellees, to purchase optional Medicare coverage) is insufficient to justify the distinctions established in Section 1903(f) of the Act. Appellees contend that reducing expenditures is an inadequate justification for distinguishing between identically situated claimants. If appellees and the categorically needy were identically situated, that argument would be pertinent. As we have already pointed out (see note 1, *supra*), however, the relevant time for comparison is *before* medical expenses have been incurred. At that point, appellees and the categorically needy are not identically situated. Appellees' failure to take sufficient steps to insure against future medical expenses provides no basis for invalidating an Act of Congress. Nor does the amount of their present medical expenses change the irrefutable fact that, at the relevant time, appellees had more money than any of the categorically needy. In a program that is designed to provide medical assistance to the poor, an applicant's income is plainly a reasonable basis for classification.

As to private insurance, appellees contend that information submitted to Congress in *1965* suggested that the aged and disabled could only purchase insurance that was expensive and that provided only limited coverage. Assuming that the information submitted to a different Congress two years before the provision at issue in this case was adopted is even relevant here, we submit that encouraging those persons who are able to purchase private insurance to do so is a perfectly rational means of reducing Medicaid expenditures. The cost of private insurance is beside the point since, as appellees recognize, private insurance premiums are not paid by the states under the Medicaid program. An individual who obtains private insurance may qualify for coverage

under a medically needy program if, after deduction of the insurance premiums, his net income is less than 133⅓% of the AFDC payment limitation. Nevertheless, the state pays only those covered medical expenses that are not paid by the private insurance company. Similarly, the limited coverage offered by some private insurance companies is also beside the point. The states have discretion to cover medical expenses for those services that are excluded under private insurance policies. See 42 U.S.C. (& Supp. III) 1396a(a)(13).[6]

---

[6] Appellees complain that the (Mot. to Aff. 23) "assumption that people 'in or close to an average income range' are better able to get adequate insurance than those on public assistance says nothing about the availability of insurance to people whose income net of medical expenses is far below the state-defined subsistence level." But Congress did not distinguish between those whose "income net of medical expenses" is below categorical assistance standards of need and any other group. The only distinction Congress created is between people whose gross income is above the categorical assistance standards (and, therefore, who are not receiving cash assistance) and those who are receiving categorical assistance. Furthermore, while Congress was prompted to take action because of states like New York that provided Medicaid coverage to individuals with incomes " 'in or close to an average income range,' " the statute makes no exception for those with incomes only slightly above the categorical assistance standards. The distinction Congress made is based on the common sense proposition that an individual with more money than another is better able to provide for himself than the individual with less money.

Appellees also seem to assume that the standard of need established under the various cash assistance programs is of significance in this case, asserting (Mot. to Aff. 5) that "eligibility for Medicaid as medically needy is determined by income standards designed to allow for the applicant's nonmedical needs." This Court's decisions make it plain that the

As to optional Medicare coverage, appellees apparently contend that because Congress *permitted* the states to purchase optional Medicare coverage and denied federal reimbursement for Medicaid expenditures that would have been unnecessary if such coverage had been purchased, the provision at issue in this case could not also have been intended to encourage participation in the Medicare program. But *permitting* the states to purchase optional Medicare coverage obviously does not *require* them to do so. Furthermore, Congress could have concluded that denial of federal reimbursement for Medicaid expenditures that might have been avoided if optional Medicare coverage had been purchased was an insufficient incentive. While the states would not be required to provide Medicaid benefits for such medical expenses, those expenses would nevertheless be deducted from the applicant's income and could result in Medicaid eligibility and expenditures for all other covered medical expenses. Those Medicaid expenditures might have been totally unnecessary if the individual had purchased optional Medicare coverage for the minimal costs established. The Medicare premium would be deducted from his gross income, as would any medical expenses not subject to payment under the Medicare program or by a third-party, but the premium and the medical expenses not covered by Medicare are likely to be significantly

---

Constitution does not require that the states provide benefits equal to the standard of need established under the cash assistance programs. See, *e.g.*, *Jefferson* v. *Hackney*, 406 U.S. 535 (1972). It follows, *a fortiori*, that the Constitution does not require the states or the federal government to provide medical assistance sufficient to allow for the Medicaid applicant's non-medical needs, as defined by the standard of need established under the categorical assistance programs.

less than the medical expenses covered by Medicare. Thus, if the applicant had purchased optional Medicare coverage, the amount of his Medicare premium and his uncompensated medical expenses might or might not be sufficient to reduce his income to an amount that satisfied the 133⅓% AFDC payment limitation. Medicaid is intended as an assistance program of last resort; steps that make it more difficult for the medically needy to qualify for benefits by encouraging that group to take advantage of the benefits provided by other programs reduce expenditures under the Medicaid program and are consistent with its character as a program of last resort.

Congress' decision to distinguish between the most needy (*i.e.*, those who have gross income less than the categorical assistance standards) and the less needy (*i.e.*, those with gross income that is greater than those standards) by treating the latter less generously than the former is completely reasonable. *Fullington* v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F. Supp. 500 (D.Colo. 1970). Congress nonetheless has decided to permit the less needy to qualify for medical assistance by deducting medical expenses. But the Constitution does not require Congress to ignore the real differences between the two groups by treating them identically in all respects.

For the foregoing reasons and the additional reasons set forth in the Jurisdictional Statement, probable jurisdiction should be noted. The Court may wish to consider summary reversal.

REX E. LEE
Solicitor General

OCTOBER 1981

APPENDIX A*

States	133 1/3% AFDC Std. of Need for One Person	Percentage AFDC Std. of Need Paid	Med. Needy Std. for One Person **	OAA Std. of Need for One Person	Percentage OAA Std. of Need Paid
1. *California*	*1600*	*86*	*1379*	*1866*	*100*
2. Connecticut	1900	100	1900	1466	100
3. *Delaware*	*1500*	*79.2*	*1190*	*1333*	*93.5*
4. Hawaii	1800	100	1800	1333	100
5. Illinois	1400	100	1400	1133	100
6. *Iowa*	*1200*	*75*	*902*	*1200*	*92*

* The information in this appendix is derived from S.Rep. No. 744, 90th Cong., 1st Sess. 178-179, Table C. (1967) and the charts in *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th *Cong.*, 1st Sess., Pt. 1, 289 (1967).

** The medically needy income standard for each state was calculated as follows:

(1) The figure in column one was divided by 1.33 to determine the AFDC standard of need for one person;

(2) The standard of need for one person was then multiplied by the figure in column two to determine the highest amount that would be paid to a single person under the state AFDC program; and

(3) The highest amount that would be paid to a single person under the state AFDC program was multiplied by 133⅓% to determine the medically needy income standard.

States	133 1/3% AFDC Std. of Need for One Person	Percentage AFDC Std. of Need Paid	Med. Needy Std. for One Person **	OAA Std. of Need for One Person	Percentage OAA Std. of Need Paid
7. Kansas	1900	100	1900	1266	100
8. Kentucky	1400	86.5	1214	1066	100
9. Maryland	1400	100	1400	1066	100
10. Massachusetts	2200	100	2200	1666	100
11. Michigan	*1500*	*82.5*	*1240*	*1333*	*100*
12. Minnesota	1800	100	1800	1200	100
13. Nebraska	*1000*	*41.6*	*417*	*1400*	*94.8*
14. New Hampshire	1700	100	1700	1266	100
15. New York	2000	100	2000	1600	100
16. North Dakota	1600	100	1600	1466	100
17. Oklahoma	1400	100	1400	1400	100
18. Pennsylvania	1600	100	1600	1200	100
19. Rhode Island	*1500*	*100*	*1500*	*1533*	*100*
20. Utah	1500	100	1500	1066	100
21. Washington	1700	100	1700	1600	100
22. Wisconsin	1800	74.1	1337	1200	85
STATES WITHOUT MEDICALLY NEEDY COVERAGE IN 1967					
1. Georgia	*1000*	*63.1*	*632*	*1000*	*88.9*
2. Idaho	1700	100	1700	1333	100

3. *Louisiana*	*1000*	*71.7*	*718*	*1533*	*72.4*
4. *Maine*	*1100*	*56.4*	*621*	*1400*	*100*
5. *Missouri*	*800*	*41.7*	*334*	*1600*	*77.3*
6. Montana	1800	100	1800	1333	100
7. *Nevada*	*1100*	*48.4*	*533*	*1666*	*100*
8. New Mexico	1500	95	1428	1333	100
9. *Ohio*	*1500*	*76.7*	*1153*	*1400*	*100*
10. Oregon	1600	97.2	1559	1200	100
11. *South Dakota*	*1600*	*80*	*1283*	*1466*	*100*
12. *Texas*	*800*	*56.7*	*454*	*1000*	*100*
13. *Vermont*	*1200*	*66.8*	*803*	*1466*	*100*
14. *West Virginia*	*1400*	*74.1*	*1039*	*1600*	*85*
15. *Wyoming*	*1600*	*83.2*	*1334*	*1600*	*75.8* *

STATES WITHOUT MEDICAID PROGRAMS IN 1967

1. *Alabama*	*500*	*31.7*	*158*	*1533*	*62*
2. *Alaska*	*900*	*43.1*	*388*	*2666*	*49.8*
3. *Arizona*	*900*	*48.6*	*438*	*1333*	*85*
4. *Arkansas*	*700*	*61.1*	*428*	*1333*	*100*
5. *Colorado*	*1100*	*75*	*827*	*1466*	*100*
6. District of Columbia	1300	100	1300	1200	100

* Because Wyoming only paid 75.8% of the Old Age Assistance standard of need, the medically needy standard is less than the OAA standard but greater than the OAA payments.

States	133 1/3% AFDC Std. of Need for One Person	Percentage AFDC Std. of Need Paid	Med. Needy Std. for One Person **	OAA Std. of Need for One Person	Percentage OAA Std. of Need Paid
7. *Florida*	*500*	*28.1*	*140*	*1333*	*67.6*
8. *Indiana*	*900*	*38.0*	*342*	*1533*	*63.7*
9. *Mississippi*	*400*	*22.8*	*91*	*1200*	*55.4*
10. New Jersey	2000	100	2000	1666	100
11. North Carolina	1200	100	1200	1133	100
12. *South Carolina*	*500*	*32.4*	*162*	*933*	*100*
13. *Tennessee*	*900*	*53*	*478*	*1133*	*97.8*
14. *Virginia*	*1300*	*90*	*1172*	*1400*	*100*

APPENDIX B

REMARKS OF REPRESENTATIVE BURTON*

Let me get to another matter. The proposed title XIX amendments, contrary to that which has been said on this floor, are absolutely antagonistic to the legislative history and the thrust of the Kerr-Mills Act. They are absolutely contrary to the original title XIX legislative intent. The intent of title XIX and the Kerr-Mills Act was to provide the medically indigent an equivalent degree of medical care provided public assistance recipients under PAMC—some means by which they could receive medical care benefits. The medically indigent by definition were those whose income did not permit them to qualify for a public assistance grant, but whose income was so limited they would not be able to meet medical costs in addition to minimum nonmedical expenses.

What position are we in with this bill? It is going to reduce Federal contributions under title XIX to California—in the next few years—by $200 to $300 million per year.

What else will it do? If one is on old-age assistance in the State of California, the average income is about $150 a month. For a married couple it can be $300 a month, if they are on old-age welfare. What if one is too proud to take welfare and the combined social security benefits between the husband and wife are a lesser amount than that which they would receive on welfare?

Under the proposed title XIX income limitation we have people drawing old-age security benefits—whose income is less than someone drawing old-age assistance, and they will be precluded—under the clear

---

* 113 Cong. Rec. 23092 (1967).

language of this bill—from getting equivalent medical care that is received by their better-off counterparts on OAA. I do not think that is a thoughtful legislative product.

My colleagues, I have made a number of statements. It can be demonstrated, if someone chooses to take issue with them, whether I have misstated the case or not. I have a few minutes of my time left, which I will not yield back. However, I invite anyone to take issue with those statements.

In the absence of being questioned, I assume—in the record—they will have to remain unchallenged.

☆ U. S. GOVERNMENT PRINTING OFFICE, 1991 398334 629

Appellee's Reply Brief

FILED
AUG 25 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-213

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

RICHARD S. SCHWEIKER, SECRETARY
OF HEALTH AND HUMAN SERVICES,

Appellant

v.

GEORGE HOGAN, ET AL.,

Appellees

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT
OF MASSACHUSETTS

MASSACHUSETTS DEFENDANTS' RESPONSE TO THE FEDERAL SECRETARY'S JURISDICTIONAL STATEMENT

FRANCIS X. BELLOTTI
Attorney General

THOMAS MILLER
MITCHELL J. SIKORA, JR.
PAUL W. JOHNSON
Assistant Attorneys General
2019 McCormack Building
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-1032
Attorneys for Massachusetts
Appellees

Table of Contents.

Introduction	1
Discussion	2
Conclusion	10

TABLE OF AUTHORITIES.

Cases.

Fullington v. Shea, 404 U.S. 963 (1971).	8
Schweiker v. Wilson, 49 LW 4207, (U.S. March 4, 1981).	9n

TABLE OF AUTHORITIES (cont.)

Constitutional and Statutory Provisions.

Fifth Amendment, U.S. Const.	2n
Fourteenth Amendment, U.S. Const.	2n
42 U.S.C. §1396a(a)(10)(C)	8, 9
42 U.S.C. §1396b(f)	2n, 9

Miscellaneous.

Social Security Amendments of 1967: Hearings on H.R. 12080 before the Senate Comm. on Finance, 90th Cong., 1st Sess.	6

Introduction.

Pursuant to Supreme Court Rule 10.4, the defendant Secretary of Human Services of the Commonwealth of Massachusetts[1/] and the defendant Commissioner of the Department of Public Welfare of the Commonwealth[2/] file the present short Response to the Jurisdictional Statement in full support of the position elaborated in that paper by the defendant-appellant Secretary of Health and Human Services.

1/ William T. Hogan, appointed in June, 1981.

2/ Thomas H. Spirito, appointed in June, 1981.

Discussion.

The Massachusetts parties subscribe to the Secretary's formulation of the question presented,[3/] the statement of the case, and the argument explaining the substantiality of the appellate questions. The state defendants urged the same views in the district court. Briefly we add or emphasize the following discrete points.

3/ From the perspective of the state defendants' the question presented in full is whether the income requirements prescribed in Section 1903(f) of the Social Security Act, 42 U.S.C. 1396(f), for state Medicaid eligibility and compliant state implementation, violate the equal protection component of the Fifth Amendment and the equal protection clause of the Fourteenth Amendment, respectively.

First, the district court acknowledged that the standard of judicial review for the equal protection challenge to the federal-state spend down requirements was one of simple rationality. Juris. Statement, 9a-10a. Both the court and the Secretary have collected the abundant authority to that effect. Id. at 10a, 24-26. Further the court conceded the presence of two legitimate governmental ends at work in the statutory four-thirds spend down policy: (1) the economy of federal expenditures; (2) and the encouragement of the use of private health insurance and Medicare as a supplement or substitute for Medicaid dependence by a less needy segment of the population. Id. at 10a. From these premises, however, it concluded somewhat elliptically that the federal statute and conforming state

program failed even the standard of minimum rationality because "(m)edically needy individuals must spend down until their income reaches an arbitrary point wholly unrelated to the SSI standards of basic need eligibility. In practical terms, this means that, in order to obtain Medicaid benefits, Social Security recipients must do with less food, clothing and shelter than their SSI counterparts." Id. at 11a. The fallacy of this reasoning, of course, is its absorption with the anomalous spend down examples and its avoidance of the generally greater ability of Social Security recipients to obviate the spend down anomaly through the purchase of supplemental private insurance. If, like the district court, one focuses narrowly upon the medically needy recipient who has not yet reached

Medicare eligibility and who has not availed himself of some additional insurance, one insists upon less rational, though still not irrational, circumstances. If, as Congress was entitled to do, one perceives a class distinctly more capable of private self-help and encourages its exercise for the prevention of the very grievance at hand, the statutory spend down levels clearly make sense.

Second, the district court's employment of legislative history in an effort to substantiate an irrational "legislative accident" is incomplete, internally inconsistent, and ultimately self-defeating. Juris. Statement, 12a-20a. Against the court's claim that congressional consideration of the four-thirds rule was minimal, id. at 13a, compare the thorough and cogent collation of

House and Senate commentary amassed by the Secretary at pages 15-17 and 18-21 of the Jurisdictional Statement. As to the court's assertion that "Congress never considered, let alone intended, the eventual effects of the four-thirds rule," id. at 19a, compare the clear warning of then HEW Undersecretary Wilbur Cohen in testimony to the Senate Finance Committee concerning the operation of the rule. Social Security Amendments of 1967: Hearings on H.R. 12080 Before The Senate Comm. on Finance, 90th Cong., 1st Sess., 259, 280-282. The court below conceded that "undersecretary Cohen did point out that the four-thirds rule would in some states force a spend down below the cash assistance level," but rationalized that "he was not testifying about the medically needy - categorically needy

discrepancy" but rather about the tendency of the four-thirds rule in some states to "exclude the categorically needy from Medicaid coverage." Id. at 13a-14a, n. 16. When one recalls that Undersecretary Cohen was testifying in general opposition to the four-thirds rule and in favor of a competing Administration proposal (150% of the highest categorical assistance income standard) and that exclusion of the categorical needy from Medicaid coverage was an even more dire consequence than the spend down anomaly threatening some of the better situated medically needy, the district court's deflection of the Undersecretary's testimony and its continued insistence upon congressional inadvertence become singularly implausible.

Third, and finally, the Court's summary affirmance in Fullington v. Shea,

404 U.S. 963 (1971), aff'g 320 F.Supp. 500 (D. Colo. 1970), upheld against an equal protection attack Colorado's policy to provide Medicaid assistance only to the categorically needy and not to the medically needy. Indeed, the district court at one point acknowledged congressional authorization of such a state decision in 42 U.S.C. §1396a-(a)(10)(C). Juris. Statement at 5a. Apparently the court would respect that provision but strike down the four-thirds rule of 42 U.S.C. 1396b(f) because Congress supposedly intended the results of the former statute but not of the latter.[4/] As the legislative his-

---

4/ In support of its conclusion of unconstitutionality by reason of congressional inattention, the district court cited no holding of this or any lower federal court. Juris. Statement at 19a.

(footnote continued)

tory makes clear, Congress was aware of the possible benefits and detriments of the spend down mechanism. The Fullington decision and the authority of 42 U.S.C. §1396a(a)(10)(C) make the present case appropriate for summary reversal.

(footnote continued)

Approximately six weeks before the entry of final judgment in the case, however, this Court concluded in a similar setting that it could not employ the rational basis standard to substitute its personal notions of good public policy for those of Congress in the distribution of welfare benefits. See Schweiker v. Wilson, 49 LW 4207, 4211-4212 (U.S. March 4, 1981).

Conclusion

For the reasons thoroughly set out in the Jurisdictional Statement of the Secretary, the Court should summarily reverse the judgment below, or should note probable jurisdiction.

Respectfully submitted,

FRANCIS X. BELLOTTI
Attorney General

THOMAS MILLER
MITCHELL J. SIKORA, JR.
PAUL JOHNSON
Assistant Attorneys General
2019 McCormack Building
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-1032

Attorneys for the State
Defendants

August 21, 1981.

Appellant's Brief

Office - Supreme Court, U.S.
FILED
DEC 7 1981
ALEXANDER L. STEVAS,
CLERK

No. 81-213

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

BRIEF FOR THE APPELLANT

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

KENNETH S. GELLER
Deputy Solicitor General

GEORGE W. JONES
Assistant to the Solicitor General

WILLIAM KANTER
BRUCE G. FORREST
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 633-2217

JUAN A. DEL REAL
General Counsel

LYNNE K. ZUSMAN
Deputy General Counsel

ROBERT P. JAYE
Acting Assistant General Counsel

DAVID R. SMITH
NANCY S. NEMON
Attorneys

Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

Whether the income requirements prescribed in Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)), a provision that limits federal reimbursement of state Medicaid expenditures, violate the equal protection component of the Fifth Amendment when applied under the Massachusetts Medicaid Program.*

---

* George Hogan, Pearl Hogan, Celia Beberman, Henry Beberman, George Hunter, and Cecilia Hunter were named plaintiffs in the district court. The district court certified a plaintiff class (J.S. App. 23a-24a) comprising "all (i) present and future Social Security recipients; (ii) who reside or will reside in Massachusetts; (iii) who are or will be disabled or 65 years old or older; (iv) who are or will be ineligible because of the amount of their incomes for Massachusetts Supplemental Security Income payments; and (v) who have or will have * * * medical expenses not subject to payment by a third party which exceed the difference between their countable incomes under the Massachusetts Medicaid regulations and the applicable Massachusetts Supplemental Security Income standard."

In addition to appellant Schweiker, the defendants in the district court were Charles Mahoney, Secretary of Human Services of the Commonwealth of Massachusetts, and John Pratt, Commissioner of the Department of Public Welfare of the Commonwealth of Massachusetts.

TABLE OF CONTENTS

	Page
Opinion below	1
Jurisdiction	1
Statutory provision involved	2
Statement	2
Summary of argument	10
Argument:	
Section 1903(f) of the Social Security Act rationally distinguishes among Medicaid applicants on the basis of income and therefore does not violate the Due Process Clause of the Fifth Amendment	14
A. Congress rationally limited the extension of Medicaid benefits to people with income greater than the standards for cash assistance	14
B. Congress intentionally established different standards of eligibility for the categorically needy and the medically needy	24
C. Section 1903(f) of the Social Security Act is valid under well-settled principles of equal protection analysis	38
Conclusion	42
Appendix	1a

TABLE OF AUTHORITIES

Cases:

Califano v. *Boles*, 443 U.S. 282	39, 40
Califano v. *Jobst*, 434 U.S. 47	18, 39
Califano v. *Torres*, 435 U.S. 1	39
Cleland v. *National College of Business*, 435 U.S. 213	41

Cases—Continued Page

Dandridge v. *Williams*, 397 U.S. 471 ..... 26, 39, 40
Fullington v. *Shea*, 404 U.S. 963, aff'g 320 F.Supp. 500 ..... 11, 19-20, 40
Harris v. *McRae*, 448 U.S. 297 ..... 2, 13, 23, 31, 39
Idaho Department of Employment v. *Smith*, 434 U.S. 100 39
Jefferson v. *Hackney*, 406 U.S. 535 ..... 14, 26, 40
Johnson v. *Robison*, 415 U.S. 361 ..... 20, 38
Maher v. *Roe*, 432 U.S. 464 ..... 13, 39, 40
Maine v. *Thiboutot*, 448 U.S. 1 ..... 12, 25, 37
Mathews v. *De Castro*, 429 U.S. 181 39
McGowan v. *Maryland*, 366 U.S. 420 39
Reed v. *Reed*, 404 U.S. 71 38
Rosado v. *Wyman*, 397 U.S. 397 ..... 14, 27
Schweiker v. *Gray Panthers*, No. 80-756 (June 25, 1981) 2, 3, 4
Schweiker v. *Wilson*, 450 U.S. 221 ..... 4, 12, 13, 17, 25, 39, 40, 41
United States v. *Clark*, 445 U.S. 23 10
United States Railroad Retirement Board v. *Fritz*, 449 U.S. 166 ..... 20, 25, 39, 42
Vance v. *Bradley*, 440 U.S. 93 ..... 39, 41, 42

Constitution, statutes and regulations:

United States Constitution:
First Amendment 18
Fifth Amendment (Due Process Clause) 6, 7, 9, 38
Fourteenth Amendment (Equal Protection Clause) 6, 7, 9
Act of July 9, 1973, Pub. L. No. 93-66, Section 212, 87 Stat. 155-158 5
Act of Dec. 31, 1973, Pub. L. No. 93-233, 87 Stat. 947 *et seq.*:
Section 10, 87 Stat. 957-958, 42 U.S.C. 1382 note 5
Section 13(c), 87 Stat. 965, 42 U.S.C. 1396a note 3
Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, Section 2171, 95 Stat. 807-808 ..... 2, 21

Constitution, statutes and regulations—Continued	Page
Social Security Act:	
Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*	4
Title II, 42 U.S.C. (& Supp. III) 401 *et seq.*	7
Title IV, 42 U.S.C. (& Supp. III) 601 *et seq.*	4, 10
Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*	4
Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.*	4
Title XVI, 42 U.S.C. (& Supp. III) 1381 *et seq.*	4
42 U.S.C. 1382e	4, 5
42 U.S.C. 1382(e)(2)	9
Title XVIII, 42 U.S.C. (& Supp. III) 1395 *et seq.*	7
Title XIX, 42 U.S.C. (& Supp. III) 1396 *et seq.*	2
42 U.S.C. 1396a(a)(10)	2, 21
42 U.S.C. 1396a(a)(10)(A)	2-3, 8, 14, 31
42 U.S.C. (1970 ed.) 1396a(a)(10)(A)	27
42 U.S.C. 1396a(a)(10)(C)	3, 4, 5, 8
42 U.S.C. 1396a(a)(10)(III)	5
42 U.S.C. 1396a(f)	3
42 U.S.C. 1396a(a)(13)	19
42 U.S.C. 1396a(a)(13)(A)	21
42 U.S.C. 1396a(a)(13)(B)	21
42 U.S.C. 1396a(a)(13)(C)	21
42 U.S.C. 1396b(f)	*passim*
42 U.S.C. 1396b(f)(1)	4, 5, 6, 8, 23, 24
42 U.S.C. 1396b(f)(2)	3
42 U.S.C. 1396b(f)(4)(A)	10
42 U.S.C. 1396b(f)(4)(C)	5
42 U.S.C. 1396d(j)	5
20 C.F.R. 416.230	9
42 C.F.R.:	
Part 435, Subpart B	3
Section 435.603	9
45 C.F.R.:	
Section 233.20(a)(2)(ii)	27
Section 233.20(a)(3)(viii)	27

Miscellaneous: Page

Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* (1968) 19
113 Cong. Rec. (1967):
p. 3899 25
p. 22781 29
p. 22783 30
p. 22784 29
p. 22785 29
p. 23048 26
p. 23055 ..... 27, 28
pp. 23061-23062 ..... 16, 30
p. 23065 28
p. 23077 28
p. 23082 28
p. 23083 ..... 28, 30
p. 23084 28
pp. 23084-23085 ..... 16, 30
p. 23087 28
p. 23090 30
p. 23091 ..... 18, 30
p. 23092 ..... 22, 28, 29
p. 23093 ..... 16, 28, 30
p. 23104 28
p. 23105 30
p. 23125 28
p. 23128 28
p. 23131 ..... 28, 29
pp. 32845-32846 34
p. 33167 34
p. 33168 34
p. 33169 ..... 16, 34
p. 33170 ..... 33, 34
p. 33171 ..... 34, 35
p. 33174 35
p. 36312 36
p. 36319 ..... 16, 36
p. 36320 16
p. 36380 35
p. 36381 36

Miscellaneous—Continued

	Page
p. 36385	36
p. 36387	36
p. 36389	36
p. 36784	36
p. 36819	36
115 Cong. Rec. (1969):	
p. 69	38
p. 85	38
p. 652	38
p. 5382	38
119 Cong. Rec. (1973):	
p. 22606	5
p. 22645	5
45 Fed. Reg. 31782 (1980)	8
46 Fed. Reg. 27076 (1981)	8
H.R. 5710, 90th Cong., 1st Sess. (1967)	25
H.R. 12080, 90th Cong., 1st Sess. (1967)	26, 27, 30, 32
H.R. 618, 91st Cong., 1st Sess. (1969)	38
H.R. 1352, 91st Cong., 1st Sess. (1969)	38
H.R. 3272, 91st Cong., 1st Sess. (1969)	38
H.R. 8283, 91st Cong., 1st Sess. (1969)	38
H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. (1967)	35
H.R. Rep. No. 213, 89th Cong., 1st Sess. (1965)	14, 15, 17, 22
H.R. Rep. No. 544, 90th Cong., 1st Sess. (1967)	16, 18, 19, 27, 28
H.R. Rep. No. 2224, 89th Cong., 2d Sess. (1966)	15, 16
H.R. Rep. No. 92-231, 92d Cong., 1st Sess. (1971)	5
H.R. Rep. No. 92-1605, 92d Cong., 2d Sess. (1972)	38
President's Proposal for Revision in the Social Security System: Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess., Pt. 1 (1967)	25, 26
S. Rep. No. 404 (Pt. 1), 89th Cong., 1st Sess. (1965)	14, 15, 22
S. Rep. No. 744, 90th Cong., 1st Sess. (1967)	16, 28, 34
S. Rep. No. 92-1230, 92d Cong., 2d Sess. (1972)	5, 23

Miscellaneous—Continued Page

S. Rep. No. 93-249, 93d Cong., 1st Sess. (1973) 5
Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess., Pt. 1 (1967) 17, 22, 26, 27, 31, 32, 33
R. Stevens & R. Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (1974) 38
United States Department of Health, Education, and Welfare, *Data on the Medicaid Program: Eligibility, Services, Expenditures* (rev. 1979 ed.) 17

In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-213

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

BRIEF FOR THE APPELLANT

OPINION BELOW

The opinion of the district court (J.S. App. 1a-20a) is reported at 501 F.Supp. 1129.

JURISDICTION

The opinion (J.S. App. 1a-20a) and initial order (J.S. App. 21a) of the district court were entered on November 21, 1980, and were clarified by an order (J.S. App. 22a) dated December 22, 1980.[1] On April

[1] The government filed a notice of appeal (J.S. App. 26a) following the entry of the district court's opinion and subsequent clarifying order, but did not docket the appeal in this Court due to uncertainty as to whether the district court had held the federal statute unconstitutional. See note 15, *infra*.

9, 1981, the district court entered a judgment pursuant to Fed. R. Civ. P. 54(b) (J.S. App. 25a) modifying its previous orders and expressly invalidating the federal statute (42 U.S.C. 1396b(f)). Notice of appeal to this Court (J.S. App. 28a-29a) was filed on April 22, 1981. On June 11, 1981, Justice Brennan extended the time for docketing the appeal to and including July 31, 1981, and the jurisdictional statement was filed on that date. The Court noted probable jurisdiction on October 13, 1981 (J.A. 45). The jurisdiction of this Court is invoked under 28 U.S.C. 1252. *United States* v. *Darusmont*, 449 U.S. 292, 293 (1981); *United States* v. *Clark*, 445 U.S. 23, 25-26 n.2 (1980).

STATUTORY PROVISION INVOLVED

Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f), is reprinted at J.S. App. 30a-32a.

STATEMENT

1. The Medicaid program was established in Title XIX of the Social Security Act, 42 U.S.C. (& Supp. III) 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Schweiker* v. *Gray Panthers*, No. 80-756 (June 25, 1981), slip op. 1. Section 1902(a)(10) of the Act (42 U.S.C. 1396a(a)(10)) establishes the basic scope of the program.[2] Participating states must provide Medicaid coverage to all persons who receive benefits under one of the categorical assistance programs (*i.e.*, the "categorically needy"). 42 U.S.C.

---

[2] Recently, Congress substantially modified Section 1902(a)(10) of the Act. Pub. L. No. 97-35, Section 2171, 95 Stat. 807-808. The basic scope of the program, however, remains the same. See note 22, *infra*.

1396a(a)(10)(A); see *Schweiker* v. *Gray Panthers*, *supra*, slip op. 2.[3] Participating states are not required to provide medical assistance to any other group of persons.[4]

A person who is not eligible for benefits under one of the cash assistance programs, therefore, is also ineligible for benefits under the Medicaid program, unless the state chooses to provide Medicaid benefits to one of the optional coverage groups. For example, a participating state may provide Medicaid benefits to persons who would be eligible for categorical assistance except for the amount of their income and resources (*i.e.*, the "medically needy"). 42 U.S.C. 1396a(a)(10)(C). Under the statute, however, a state is entitled to receive federal financial assistance for providing Medicaid benefits to a "medically needy" individual only if that person has incurred medical expenses equal to or greater than the difference between his countable income and the medically needy spend down level. *Ibid.*[5] The medically needy spend

---

[3] The so-called "209(b) option" creates an exception to this general requirement, but is immaterial in the present context. See 42 U.S.C. 1396a(f); see generally *Schweiker* v. *Gray Panthers*, *supra*, slip op. 3-4 & nn.4-6.

[4] As is true of most general statements concerning this "intricate" statute (*Schweiker* v. *Gray Panthers*, *supra*, slip op. 8), there are several exceptions to the statement in the text. See, *e.g.*, Act of Dec. 31, 1973, Pub. L. No. 93-233, Section 13(c), 87 Stat. 965, 42 U.S.C. 1396a note (medicaid eligibility for mandatory state supplementary payment recipients); see generally 42 C.F.R. Part 435, Subpart B. None of these exceptions is material in this case.

[5] The term "spend down" is somewhat misleading. The statute only requires the "medically needy" applicant to "incur" medical expenses. See 42 U.S.C. 1396b(f)(2). Eligibility is not dependent on actual payment of the debt during the relevant period. Moreover, if the medically needy spend down level is higher than the categorically needy income limit,

down level for a person with a family of a given size must not exceed 133⅓% of the amount that would be paid to a family of the same size under the state Aid to Families with Dependent Children (AFDC) program (42 U.S.C. (& Supp. III) 601 *et seq.*). See 42 U.S.C. 1396a(a)(10)(C) and 1396b(f)(1). Thus, if the AFDC payment in a particular state were $300, a medically needy individual with monthly income of $600 would not be eligible for Medicaid until he had incurred medical expenses of at least $200 [*i.e.*, $600 − ($300 × 133⅓%)].

In 1972, Congress replaced three of the four state-administered categorical assistance programs with a new federal program called Supplemental Security Income for the Aged, Blind, and Disabled (SSI), 42 U.S.C. (& Supp. III) 1381 *et seq. Schweiker* v. *Gray Panthers*, *supra*, slip op. 3.[6] Although the SSI program establishes a "Federal guaranteed minimum income level" for the aged, blind, and disabled (*Schweiker* v. *Wilson*, 450 U.S. 221, 223 (1981)), the states may supplement the minimum benefit payment provided under the federal program. See 42 U.S.C. 1382e.[7] If a state chooses to make supplementary

---

an individual whose income is greater than the categorically needy limit but lower than the spend down level would be eligible for benefits as medically needy without incurring any medical expenses.

[6] As its name indicates, the SSI program replaced the categorical assistance plans for the aged, blind, and disabled. See Old Age Assistance (OAA), Title I, 42 U.S.C. (1970 ed.) 301 *et seq.*; Aid to the Blind (AB), Title X, 42 U.S.C. (1970 ed.) 1201 *et seq.*; Aid to the Permanently and Totally Disabled (APTD), Title XIV, 42 U.S.C. (1970 ed.) 1351 *et seq.* The AFDC program (42 U.S.C. (& Supp. III) 601 *et seq.*) is still administered by the states and is only partially funded by the federal government.

[7] In most states, adoption of the SSI program resulted in an increase in benefits for aged, blind, and disabled categori-

payments (see 42 U.S.C. 1396d(j)) to SSI benefit recipients or to persons who would be eligible for SSI benefits except for the amount of their income, the state may also provide Medicaid benefits to those persons under limited circumstances. 42 U.S.C. 1396a(a)(10)(III), 1396b(f)(4)(C).[8]

The Commonwealth of Massachusetts has chosen to participate in the Medicaid program and to provide Medicaid benefits to the "medically needy" (see 42 U.S.C. 1396a(a)(10)(C)), but only to those persons for whom it will receive federal financial assistance (see 42 U.S.C. 1396b(f)(1)). Massachusetts also has chosen to make supplementary payments to persons eligible for SSI benefits or who would be eligible for SSI benefits except for their income (see 42 U.S.C. 1382e), and to provide Medicaid benefits to those persons (see 42 U.S.C. 1396a(a)(10)(III)). The constitutional challenge presented by appellees is based on the fact that, in some cases,

---

cal assistance recipients. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 78-91, Tables 3 & 4 (1972); see also *id.* at 75; H.R. Rep. No. 92-231, 92d Cong., 1st Sess. 199 (1971). To prevent any reduction in benefits to categorical assistance recipients in those states that had maintained higher benefit levels than provided for under the SSI program, Congress required those states to make supplementary payments under some circumstances. Act of July 9, 1973, Pub. L. No. 93-66, Section 212, 87 Stat. 155-158, as amended by the Act of Dec. 31, 1973, Pub. L. No. 93-233, Section 10, 87 Stat. 957-958, 42 U.S.C. 1382 note; see 119 Cong. Rec. 22606 (1973) (remarks of Sen. Long); *id.* at 22645 (remarks of Rep. Mills); S. Rep. No. 93-249, 93d Cong., 1st Sess. 24-25 (1973).

[8] A state is entitled to federal financial assistance for providing Medicaid benefits to a state supplementary payment recipient (who is ineligible for SSI benefits) only if his gross income is less than 300% of the applicable SSI income limitation. 42 U.S.C. 1396b(f)(4)(C).

133⅓% of the appropriate Massachusetts AFDC-payment amount is less than the combined federal SSI-state supplementary payment level.[9]

2. Appellees filed suit in the United States District Court for the District of Massachusetts, challenging the maximum medically needy spend down level prescribed in Section 1903(f)(1) of the Social Security Act (42 U.S.C. 1396b(f)(1)) as violative of the equal protection component of the Due Process Clause of the Fifth Amendment, and the corresponding state provisions as violative of the Equal Protection Clause of the Fourteenth Amendment. Complaint, Count I (J.A. 21-22).[10] Each of the appellees or his spouse

---

[9] For example, assume that (1) the monthly Massachusetts supplementary payment level is $525, (2) the monthly SSI payment level is $350, and (3) the monthly Massachusetts AFDC payment level is $300. The combined federal SSI-state supplementary payment level is, therefore, $525. An aged individual with monthly income below that amount would be entitled to categorical assistance payments and Medicaid benefits. The medically needy spend down level would be $400 ($300 × 133⅓%). Accordingly, an aged individual with monthly income of $600 would be ineligible for any SSI or state supplementary payment; if he incurred medical expenses of $200 ($600-$400), he would be eligible for Medicaid benefits, and any covered medical expenses in excess of $200 would be paid by the state. If the medically needy individual in this example paid the $200 medical expense in the month in which it was incurred, he would have $125 less available *in that month* for non-medical expenses than a cash assistance recipient.

Massachusetts uses a six-month accounting period to determine Medicaid eligibility for the medically needy, and therefore the individual in this example would have to incur medical expenses of $1200 to qualify for assistance in any six-month period.

[10] Appellees also challenged the federal and state provisions requiring them to "apply for and accept all Social Se-

had been employed at some point in his career and during that time paid "Social Security taxes" (J.S. App. 2a). Each of the appellees (or his spouse) receives Federal Old-Age, Survivors, and Disability Insurance (OASDI) benefits (42 U.S.C. (& Supp. III) 401 *et seq.*) in amounts that render him ineligible for either SSI benefits or state supplementary payments.[11] Because the Massachusetts supplementary payment standard is higher than 133⅓% of the Massachusetts AFDC payment level in some cases, payment of the medical expenses incurred to qualify for Medicaid benefits may leave some "medically needy" persons with less income for non-medical expenses than "categorically needy" persons may have for non-medical expenses. Appellees complained that since they worked for substantial periods of time and paid Social Security taxes, it was wholly irrational for Congress to treat them less favorably under the Medicaid program than

---

curity benefits for which they are eligible as a condition of application for SSI and Medicaid, 42 U.S.C. § 1382(e)(2); 20 C.F.R. § 416.230; 42 C.F.R. § 435.603; MPAPM, ch. IV, § B, p.4 * * *" as violative of the equal protection requirements of the Fifth and Fourteenth Amendments. Complaint, Count II (J.A. 22). In Count III of their complaint, appellees charged that Massachusetts' six-month accounting period for determining the eligibility of the medically needy is inconsistent with the requirements of the Social Security Act (see J. S. App. 3a n.3).

[11] Many of the appellees presumably are eligible for benefits under the Medicare program (42 U.S.C. (& Supp. III) 1395 *et seq.*) and at least some of their medical expenses are paid under that program. See, *e.g.*, Complaint, ¶ 38 (J.A. 18-19). The plaintiff class certified by the district court, however, includes only those OASDI beneficiaries who have incurred medical expenses in addition to those paid under the Medicare program or by some other third-party such as a private insurance company. See J.S. App. 23a-24a.

welfare recipients (*i.e.*, the categorically needy), who may or may not ever have worked or paid any taxes.[12]

On cross motions for summary judgment as to Counts I and II of the complaint, the district court held "the Massachusetts Medicaid program unconstitutional insofar as it forces Social Security recipients to spend down [*i.e.*, incur medical expenses that may reduce their income to an amount] below Supplemental Security Income levels before receiving medical benefits" (J.S. App. 20a).[13] The district court entered an order granting appellees' motion for par-

---

[12] In other words, appellees paid Social Security taxes during their work careers and now receive OASDI benefits. Each of them has more total income than any SSI, AFDC, or state supplementary payment recipient (i.e., the categorically needy) and, therefore, can only qualify for Medicaid benefits under the Massachusetts program as "medically needy." Because appellees are ineligible for benefits under any of the categorical assistance programs, they are not entitled to Medicaid benefits unless they incur medical expenses in excess of the difference between their incomes and 133⅓% of the relevant AFDC payment amount (*i.e.*, the medically needy spend down level). See 42 U.S.C. 1396a(a)(10)(A) and (C), 1396b(f)(1). The so-called "spend down" requirement (see note 4, *supra*) is applicable to the medically needy but not to the categorically needy. Appellees asserted that, as a consequence, they are left with less money, after medical expenses, than the categorically needy. This "discrimination" between themselves and the categorically needy, appellees maintained, could not have been intended by Congress.

[13] It is clear that 133⅓% of the Massachusetts AFDC payment level (*i.e.*, the medically needy spend down level) is higher than federal SSI benefit levels. See 45 Fed. Reg. 31782 (1980); 46 Fed. Reg. 27076 (1981). The district court's reference to "Supplemental Security Income levels" must have been intended to refer to state supplementary payment levels.

tial summary judgment (*id.* at 21a).[14] In a supplemental order, the district court sought to clarify the nature of its holding, stating (J.S. App. 22a):

> It is the confluence of federal and state requirements which renders the Massachusetts program unconstitutional. It is that federal-state program which this court held to be unconstitutional, and not merely the Massachusetts medicaid statute.

Finally, on April 9, 1981, the district court directed that final judgment be entered on Counts I and II of the complaint and modified its prior decision by expressly holding Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) unconstitutional (J.S. App. 25a): "[T]he court states that its ruling holds unconstitutional, in addition to the Massachusetts Medicaid income eligibility standards applied to the plaintiff class, the federal statute limiting Medicaid reimbursement, 42 U.S.C. section 1396b(f)."[15]

---

[14] While the district court purported to grant appellees' motion for partial summary judgment on Counts I and II of the complaint, the court never discussed the claim in Count II that requiring appellees "to apply for and accept all Social Security benefits" as a condition of eligibility for both SSI benefits and Medicaid benefits violates the equal protection requirements of the Fifth and Fourteenth Amendments. We do not believe that the district court intended to invalidate a federal statute (42 U.S.C. 1382(e)(2)) and implementing regulations (20 C.F.R. 416.230; 42 C.F.R. 435.603) without discussion. In any event, Congress reasonably has chosen to treat SSI and Medicaid as assistance programs of last resort and, therefore, has required individuals to seek assistance from a program that is partially funded by their specific contributions or from other sources before resorting to programs that are funded entirely from general revenues. There is no constitutional infirmity in such a requirement.

[15] The district court's opinion (J.S. App. 1a-20a) and its initial order (*id.* at 21a) were issued on November 21, 1980. The order clarifying the decision and initial order (*id.* at 22a)

SUMMARY OF ARGUMENT

1. Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) is a reasonable limitation on federal Medicaid expenditures. Under Section 1903(f), a participating state is entitled to federal financial assistance for providing Medicaid benefits to an individual classified as medically needy only if he has incurred medical expenses greater than the difference between his countable gross income and 133⅓% of the amount that would be paid to a family of the same size as his with no income under the state's Aid to Families with Dependent Children (AFDC) program (42 U.S.C. (& Supp. III) 601 *et seq.*). This limitation on federal financial assistance is inapplicable to state Medicaid expenditures on behalf of the categorically needy. 42 U.S.C. 1396b(f)(4)(A). By definition, individuals classified as medically needy have more income than the categorically needy and therefore are reasonably regarded as less needy. Thus, the distinction between the categorically needy and the medically needy in Section 1903(f) rests on the irrefutable proposition that individuals who can only qualify for Medicaid as medically needy are generally

---

was issued on December 22, 1980. Following the December 22, 1980 order, the government filed a notice of appeal to this Court (*id.* at 26a). Because there was still considerable uncertainty as to whether the court had invalidated a federal statute, and, if so, which one, the parties sought further clarification. On April 9, 1981, the district court issued the judgment from which the instant appeal is taken, leaving no doubt that Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) had been held unconstitutional. Because the time for docketing the appeal from the December 22 order in this Court had expired, the government filed a second notice of appeal. See *United States* v. *Clark*, 445 U.S. 23, 26 n.2 (1980).

better able to provide for their own medical expenses—by purchasing insurance or in some other way—than the categorically needy, because they have more income. In a program designed to provide medical assistance to the poor, income is plainly a rational basis for classification. *Fullington* v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F.Supp. 500 (D.Colo. 1970).

The distinction between the categorically needy and the medically needy recognized in Section 1903(f) is not rendered unreasonable by the fact that 133⅓% of the applicable AFDC payment standard in Massachusetts is sometimes less than the income limits applicable to the categorically needy. The relevant time for comparing the categorically needy and the medically needy in a program such as Medicaid is *before* medical expenses are incurred. At that moment, the categorically needy and the medically needy are not similarly situated, because members of the latter group have more resources to devote to future medical costs than do members of the former group.

In light of this distinction, the Medicaid Act need not have included any protection for the medically needy. *Fullington* v. *Shea*, *supra*. Congress has determined, however, to allow the less needy to qualify for Medicaid benefits by deducting medical expenses. But the Constitution does not require Congress to ignore the real differences between the two groups by treating them identically in all respects. Indeed, the district court's analysis, by comparing the medically needy and the categorically needy *after* the payment of medical expenses, would preclude any disparity in treatment, contrary to this Court's decision in *Fullington* v. *Shea*, *supra*.

Moreover, although a spend down level is a kind of income limitation, its operation and effect is significantly different from an income limit of the sort applicable to the categorically needy. An income limitation applicable to income net of specified expenses is obviously not directly comparable to a limitation applicable to gross income. In addition, while the medically needy spend down level has no significance outside of the Medicaid program, the SSI income limitations, which define the categorically needy for purposes of Medicaid, also establish a "Federal guaranteed minimum income level" for the aged, blind, and disabled. *Schweiker* v. *Wilson*, 450 U.S. 221, 223 (1981).

Finally, because the purpose of the Medicaid program is to provide medical assistance to the poor and not to assure some minimum amount of money for non-medical expenses, it is wholly inappropriate to evaluate the reasonableness of Section 1903(f) by comparing the amount of money that may be available to the categorically needy for non-medical expenses with the amount of money that may be available to the medically needy for such expenses after the medical expenses that the latter group must incur to qualify for Medicaid assistance have been paid. Thus, contrary to the district court's apparent assumption, there is no necessary relationship between the income limits applicable to the categorically needy and the flexible spend down levels applicable to the medically needy.

2. Section 1903(f) was not the product of "a legislative accident" (J.S. App. 19a). Rather, "Congress was aware of what it was doing, and the legislative history does not demonstrate that the plain language was not intended." *Maine* v. *Thiboutot*, 448 U.S. 1, 8 (1980).

The major purpose of Section 1903(f) was to limit federal expenditures under the Medicaid program. Congress carefully considered three distinct proposals, each of which was directed at limiting federal assistance to the medically needy. The proposal that was ultimately adopted had been repeatedly criticized in both the House and the Senate on the ground that it was too restrictive. Data before Congress plainly indicated that in many states 133⅓% of the AFDC payment amount would result in a medically needy spend down level that was lower than the income limitations applicable to the categorically needy.

Given the attention that the proposed Medicaid limitations received in 1967, Congress could not have overlooked the significance of this data. More important, the plain meaning of Section 1903(f) is unambiguous, and there is nothing in the legislative history of the provision that even suggests that Congress did not mean exactly what it said.

3. Under well-settled principles of equal protection analysis, Section 1903(f) is plainly constitutional. The distinction between the categorically needy and the medically needy recognized in Section 1903(f) does not infringe any right or liberty protected by the Constitution. See *Maher* v. *Roe*, 432 U.S. 464, 489 (1977). Thus, unless the classification rests on grounds wholly irrelevant to the achievement of any legitimate objective, it must be sustained. *Harris* v. *McRae*, 448 U.S. 297, 322 (1980).

Section 1903(f) was intended to limit federal expenditures under the Medicaid program, in view of budgetary constraints. This obviously is a legitimate legislative objective. *Schweiker* v. *Wilson*, 450 U.S. 221, 239 (1981). The statutory classification chosen to reduce costs distinguishes between the categorically needy and the medically needy. This distinction is

rational because individuals who can only qualify for Medicaid benefits as medically needy have more income than the categorically needy and, as a result, are generally better able to prepare for their anticipated medical expenses than the categorically needy. In a program designed to provide medical assistance for the poor, Congress rationally determined to concentrate limited funds where the need was thought to be greatest.

ARGUMENT

SECTION 1903(f) OF THE SOCIAL SECURITY ACT RATIONALLY DISTINGUISHES AMONG MEDICAID APPLICANTS ON THE BASIS OF INCOME AND THEREFORE DOES NOT VIOLATE THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT

A. Congress rationally limited the extension of Medicaid benefits to people with income greater than the standards for cash assistance

Income limitations under the Medicaid program, as enacted in 1965, were left almost entirely to the discretion of participating states.[16] See H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965); S. Rep. No. 404 (Pt. 1), 89th Cong., 1st Sess. 77-78 (1965). Congress

[16] Before the SSI statute was enacted, the states administered the categorical assistance programs for the aged, blind, and disabled as well as the program for families with dependent children. Under each of the old categorical assistance programs, the individual states set both the "standard of need" and the "level of benefits." See generally *Jefferson* v. *Hackney*, 406 U.S. 535, 541, 542 (1972); *Rosado* v. *Wyman*, 397 U.S. 397, 408-409 (1970). In establishing the income limits for the categorical assistance programs, the states also established the income limits for the categorically needy under the Medicaid program. See 42 U.S.C. 1396a(a)(10)(A). The Medicaid statute has never prescribed income limits for the medically needy.

initially relied on the presumed desire of the states to limit their own expenditures under the Medicaid program as the method of containing federal matching expenditures, as it had done with respect to the categorical assistance programs. From the beginning, however, Congress perceived Medicaid as essentially a limited public assistance program for the "needy." See, *e.g.*, H.R. Rep. No. 213, *supra*, at 66; S. Rep. No. 404 (Pt. 1), *supra*, at 77; H.R. Rep. No. 2224, 89th Cong., 2d Sess. 1 (1966).[17] The Medicaid Act became effective in January 1966; by October 1966, Congress recognized the imprudence of relying on the states to limit expenditures in the Medicaid context and began to seek ways to restrict the amount of federal expenditures under the program. See H.R. Rep. No. 2224, *supra*, at 1-3.[18]

---

[17] "Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under * * * [any of the categorical assistance programs]. These people are *the most needy in the country* and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to *the less needy* than those who would be eligible for aid under the various *other categories of public assistance*." H.R. Rep. No. 213, *supra*, at 66 (emphasis added).

[18] "The Committee on Ways and Means at this time, has been unable to develop a formula applying specific fiscal limitations as to Federal participation in title XIX which would be both effective and equitable. It has given consideration to a number of proposed methods of limiting future Federal financial liability with respect to overall limitation of State plans and of eligibility limitations on the income of individuals and families for whom payments might be made with Federal financial participation, particularly those with attachments

1. Given the need to limit federal expenditures under the Medicaid program, Congress had essentially three choices in 1967, when Section 1903(f) was adopted: (1) to reduce expenditures on behalf of all Medicaid beneficiaries; (2) to reduce expenditures on behalf of the categorically needy, "the most needy" people in the country; or (3) to reduce expenditures on behalf of the medically needy. Congress chose the third alternative. Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)), the means chosen by Congress, effectively and reasonably limits the federal government's Medicaid obligations. A participating state is entitled to federal financial assistance for providing Medicaid benefits to an individual classified as medically needy only if he has incurred medical expenses greater than the difference between his countable gross income and 133⅓% of the amount that would be paid to a family of the same size as his with no income under the state's AFDC program. The major purpose of the provision was simply to save money. See, *e.g.*, H.R. Rep. No. 544, 90th Cong., 1st Sess. 5, 18, 117-119 (1967); S. Rep. No. 744, 90th Cong., 1st Sess. 5, 175-177 (1967); 113 Cong. Rec. 23093 (remarks of Rep. Mills), 23061 (remarks of Rep. Byrnes), 23084-23085 (remarks of Rep. Hanley), 33169 (remarks of Sen. Long), 36319 (remarks of Sen. Curtis), 36320 (1967) (remarks of Sen.

---

to the labor force that generally afford access to health insurance protection. Your committee wishes to make its intention clear, however, that such a formula may be developed and it therefore now cautions the States to avoid unrealistic levels of income and resources for title XIX eligibility purposes. Your committee will continue to study appropriate means of achieving these goals * * *." H.R. Rep. No. 2224, *supra*, at 2-3; see also *id.* at 26-27 (supplemental views of Rep. Curtis).

Anderson); see also *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess., Pt. 1, 275-279 (1967) ("*1967 Senate Hearings*").

Medicaid is a public assistance program for providing medical care to the needy. The categorically needy are among "the most needy [people] in the country" (H.R. Rep. No. 213, *supra*, at 66).[19] By definition, the medically needy have more income than the categorically needy and therefore are regarded as *less* needy. Congress' decision to reduce federal expenditures on behalf of the medically needy and not the categorically needy rests on the irrefutable proposition that individuals in the medically needy group are generally better able to provide for their own medical expenses—by purchasing insurance or in some other way—than individuals in the categorically needy group. Whatever the income limitation used to define the categorically needy group, of course, a person who has income that is only slightly above the limit is necessarily only slightly better able to fend for himself than a person with income that is only slightly below the limit. Compare *Schweiker* v. *Wilson*, 450 U.S. 221, 238 (1981). Nevertheless, people in the group with income in excess of the prescribed

---

[19] There are people with as little income as the categorically needy who are nevertheless ineligible for Medicaid. With immaterial exceptions, only those persons who are over 65 years old, blind, disabled, or members of families with dependent children are eligible for Medicaid assistance, however low their income. It has been estimated that in 1970 only about 59% of those who had income less than the national poverty standard were Medicaid recipients. See United States Department of Health, Education, and Welfare, *Data on the Medicaid Program: Eligibility, Services, Expenditures* 62-63 (rev. 1979 ed.).

amount are generally better able to fend for themselves than those in the group with less income. The reasonableness of a legislative classification cannot be judged by the cases at the margin. See, *e.g.*, *Califano* v. *Jobst*, 434 U.S. 47, 63 (1977).

Section 1903(f) effectively increases the "cost" to the medically needy of obtaining Medicaid benefits and thus encourages those who are generally in a better position to do so to purchase private insurance (or, in the case of most if not all of the appellees, to purchase optional Medicare coverage).[20] The provision

---

[20] Congress believed that there were some state Medicaid plans that operated as disincentives to the purchase of private health insurance and to participation in the optional Medicare program; Congress feared that without some limitations other states might follow this example. See, *e.g.*, H.R. Rep. No. 544, *supra*, at 118; 113 Cong. Rec. 23091 (1967) (remarks of Rep. Stratton). "The provisions of the bill are directed toward eliminating, insofar as Federal sharing is concerned, these clearly unintended and, in your committee's judgment, undesirable actual and potential effects of the legislation" (H.R. Rep. No. 544, *supra*, at 118).

The district court acknowledged that at least one of Congress' purposes in adopting the 133⅓% limitation was to encourage the purchase of private health insurance (J.S. App. 20a). The court nonetheless dismissed that purpose as insufficient to support Section 1903(f) (*ibid.*):

> The expressed purpose to prevent duplication of middle income families' private health insurance, however, cannot support a rule which cuts so deeply into the basic needs of some of society's poorest individuals.

If this were a First Amendment case, the district court's "overbreadth" analysis might be appropriate. But it has no place in a case such as this involving economic policy choices of Congress. The House report expressly states that "the operation of some State plans may greatly reduce the incentives for persons aged 65 or over to participate in the sup-

"reflects the assessment by Congress of the realities of * * * fiscal needs and priorities and represents use of an effective tool for imposing controls on potentially the greatest source of additional cost of the medical care program, namely, the services to the medically needy." Advisory Commission on Intergovernmental Relations, *Intergovernmental Problems in Medicaid* 64 (1968). Encouraging the medically needy to purchase private insurance and to participate in the optional Medicare program, we submit, is a rational means of limiting federal expenditures and is consistent with the character of the Medicaid program as a program of last resort.[21]

Appellees concede (Mot. to Aff. 7) that Congress could have eliminated all federal Medicaid expenditures on behalf of the medically needy. See *Fulling-*

---

plementary medical insurance program [Medicare, Part B]" (H.R. Rep. No. 544, *supra*, at 118). The district court erroneously concluded (J.S. App. 19a-20a & n.20) that Congress addressed this problem by permitting the states to purchase Medicare coverage on behalf of some Medicaid recipients.

[21] Contrary to appellees' argument (Mot. to Aff. 24-25) the high cost of private insurance for the aged or disabled does not make it irrational to encourage people to buy such insurance as a means of reducing Medicaid expenditures. Insurance premiums may be deducted from gross income so that a medically needy person may qualify for Medicaid, but the state pays only those covered expenses that are not paid by the private insurance company. Similarly, the limited coverage offered by some private insurance companies is beside the point. Under Section 1902(a)(13) (42 U.S.C. 1396a(a)(13)), the states had broad discretion as to the services that would be offered to the medically needy. Those services excluded by the private insurance company might also have been excluded under the state Medicaid plan. See also note 22, *infra*.

ton v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F.Supp. 500 (D. Colo. 1970). Congress' decision to adopt a more moderate approach is no less reasonable. *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 177 (1980). The only basis for distinguishing between the categorically needy and the medically needy is by reference to gross income. If, as this Court held in *Fullington* v. *Shea*, that difference is sufficient to support a decision to provide Medicaid benefits *only* to the categorically needy and to deny all Medicaid benefits to the medically needy, the relevant time for comparison of the two groups necessarily is *before* medical expenses have been incurred. In a program intended to provide medical assistance for the poor, an applicant's income is plainly a legitimate basis for classification. Since the categorically needy and the medically needy are not similarly situated with respect to income, Congress' decision to treat the two groups differently by imposing different kinds of income criteria is perfectly reasonable. See, *e.g.*, *Johnson* v. *Robison*, 415 U.S. 361, 374 (1974).

The district court erroneously concluded that the time for comparison is *after* the medically needy have incurred medical expenses. See J.S. App. 12a. That view, of course, would preclude any differences in treatment between the medically needy and the categorically needy. All participating states (contrary to the holding in *Fullington*) would be required to adopt medically needy programs, and the scope of services offered the two groups presumably would have to be the same. These results would follow from the district court's equal protection analysis because, as noted above, after the deduction of medical expenses there is no difference between the categorically needy and the medically needy. But Congress has

consistently distinguished between the categorically needy and the medically needy. Thus, acceptance of the district court's analysis in this case might well require invalidation of several other provisions of the Medicaid Act. See, *e.g.*, Pub. L. No. 97-35, Section 2171, 95 Stat. 807-808.[22]

2. Contrary to the district court's apparent assumption (J.S. App. 11a), there is no necessary relationship between the absolute income limitations applicable to the categorically needy and the flexible spend down levels applicable to the medically needy. Although a spend down level is a kind of income limitation, it is significantly different from the sort of income limitation applicable to the categorically needy. For obvious reasons, an "income limitation" applicable to income net of specified expenses is not directly comparable to a limitation applicable to gross income.[23] Furthermore, while the medically needy spend

---

[22] Section 2171 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35, 95 Stat. 807-808) substantially modifies the language of Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)). Participating states are still required to provide Medicaid benefits to all of the categorically needy and permitted to provide Medicaid benefits to the medically needy. Section 2171 also specifies the minimum services to be provided for the categorically needy, but leaves the scope of services to be provided for the medically needy to the discretion of the states. Section 1902(a)(13)(A), (B), and (C), which had specified certain minimum services for the medically needy, was repealed.

[23] The consequences of applying one sort of limitation or the other are quite different. For example, however great their expenses for food and shelter, appellees are ineligible for any SSI benefit or state supplementary payment so long as their gross income is in excess of the applicable limit. On the other hand, no matter how much greater than the spend down level his income may be, each of the appellees can

down level is of no consequence outside the Medicaid program, the SSI income limits—which define the categorically needy for purposes of Medicaid—are first and foremost the amounts the federal government is willing to assure to every aged, blind, and disabled person in the country.[24] Congress could have prescribed income limitations for the Medicaid program that were independent of and completely different from those that define eligibility for SSI benefits. Congress' decision to require participating states to provide Medicaid benefits to those who are receiving SSI benefits does not preclude a maximum spend down level for the medically needy that is independent of the SSI income limitations.[25]

---

qualify for Medicaid benefits if he incurs sufficient medical expenses. Thus, unlike the categorically needy income limits, the spend down level offers the medically needy a "second chance" to qualify for Medicaid benefits.

[24] Similarly, the Massachusetts supplementary payment income limits reflect the extent to which that state is willing to supplement the federally guaranteed minimum.

[25] It is unnecessary to quarrel with the district court's assertion (J.S. App. 12a) that "in 1965 [Congress] clearly meant to prohibit the states from forcing anyone to spend down below categorically needy income standards." Indeed, we concede that there is support in the legislative history of the 1965 legislation for that conclusion. See S. Rep. No. 404 (Pt. 1), *supra*, at 78-79; H.R. Rep. No. 213, *supra*, at 68. See also *1967 Senate Hearings* 784; 113 Cong. Rec. 23092 (1967) (remarks of Rep. Burton). We note, however, that the 1965 legislative history is not unambiguous, and, more important, the language of the statute did not expressly impose any such limitation. In any event, whatever Congress' original intention may have been, the legislative history of Section 1903(f) (see pages 25-37, *infra*) makes it plain that in 1967 Congress did not perceive any necessary relationship between the Medicaid income limits for the categorically needy and the spend down level that would apply to the medically needy.

Similarly, it is wholly inappropriate to evaluate the reasonableness of Section 1903(f)(1) by comparing the amount of money the categorically needy may have available for non-medical expenses with the amount of money the medically needy may have available for non-medical expenses, after the latter group has paid its medical bills. Unlike the SSI program, which was intended to provide a "Federal guaranteed minimum income level for aged, blind, and disabled persons" (S. Rep. No. 92-1230, 92d Cong., 2d Sess. 12 (1972)), the Medicaid program was created "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons" (*Harris* v. *McRae*, 448 U.S. 297, 301 (1980)). The reasonableness of the limitation imposed by Section 1903(f), therefore, does not depend upon the extent to which it protects some minimum amount of money for *non-medical* expenses. That is not its purpose or the purpose of the Medicaid program. The categorically needy and the medically needy are not similarly situated with respect to income. Accordingly, Congress reasonably prescribed different standards of eligibility for the two groups. So long as the differences in those standards are rational, as they surely are here, the fact that the two standards have different collateral consequences for the two groups is irrelevant.

3. In 1967, Congress decided that it was necessary to limit federal expenditures under the Medicaid program. Because Congress concluded that the medically needy were generally better able than the categorically needy to take steps to ensure that future medical expenses could be paid, it chose to limit federal Medicaid expenditures only on behalf of the medically needy. Instead of imposing an absolute income limitation of the sort applicable to the categorically needy,

Congress decided to prescribe a flexible maximum spend down level.

The particular formula prescribed in Section 1903(f) is both effective and reasonable, though there are doubtless other formulae that might be no less effective and no less reasonable. In each state the maximum spend down level for the medically needy depends on the state's AFDC payment standard, which in 1967 was the lowest of the cash assistance standards. The amount of medical expenses an individual must incur to qualify for Medicaid benefits varies depending on his income. The lower an individual's income, the less the amount of the medical expenses that he must incur. Thus, while different from the sort of income limitations applicable to the categorically needy, the maximum spend down level prescribed by Section 1903(f)(1) is sensible and accomplishes the legislative purpose. The provision limits federal Medicaid expenditures by drawing reasonable distinctions (i) between the categorically needy and the medically needy and (ii) among the medically needy.

B. Congress intentionally established different standards of eligibility for the categorically needy and the medically needy

The difference in treatment of the categorically needy and the medically needy under the Medicaid program is not the result of inadvertence or, as the district court asserted (J.S. App. 18a), a failure to "recognize the full implications of the four-thirds rule." Congress was aware that 133⅓% of the AFDC payment amount in some states was less than the income limitations that determined the Medicaid eligibility of the categorically needy. Nevertheless, Congress enacted Section 1903(f)(1), by its terms applicable to the medically needy but not to the categorically

needy. Indeed, there would have been no reason to exempt the categorically needy from the limitations imposed by Section 1903(f) if 133⅓% of the AFDC payment amount would not sometimes be lower than the income limitations that determined the Medicaid eligibility of the categorically needy. Hence, as we show below, "Congress was aware of what it was doing, and the legislative history does not demonstrate that the plain language was not intended." *Maine* v. *Thiboutot*, 448 U.S. 1, 8 (1980); see *Schweiker* v. *Wilson*, *supra*, 450 U.S. at 236; *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 179 (1980).

1. One year after the effective date of the Medicaid statute, Representative Mills introduced an administration-sponsored bill that would have made significant changes in the categorical assistance programs as well as in the Medicaid program. H.R. 5710, 90th Cong., 1st Sess. (1967); see 113 Cong. Rec. 3899 (1967).[26] Two of the provisions of H.R. 5710 are of particular importance here. Under Section 220 of the bill, a state participating in the Medicaid program would have been entitled to receive federal financial assistance for providing Medicaid benefits only to those persons whose income, after deduction of incurred medical expenses, was less than 150% of *the highest* of the state's categorical assistance standards of need. *1967 House Hearings* 65, 91. This provision, of course, would have had no effect on any of the categorically needy since their income was necessarily less than 150% of the highest categorical

---

[26] The administration-sponsored bill is reprinted in *President's Proposals for Revision in the Social Security System: Hearings on H.R. 5710 Before the House Comm. on Ways and Means*, 90th Cong., 1st Sess., Pt. 1, 26-27 (1967) (*"1967 House Hearings"*).

assistance standard of need. It could only have been intended to limit the scope of coverage provided to the medically needy.

Section 202 of the administration-sponsored bill would have required the states to revise the standards of need under each of the categorical assistance programs annually to reflect changes in the costs of living and, in some circumstances, to pay 100% of the standard of need established under the programs. See *1967 House Hearings* 59, 90. In support of Section 202, the Department of Health, Education, and Welfare (now Health and Human Services) explained that "33 States provide less support for needy children [under the AFDC program] than the standards the States themselves have set as necessary to meet basic human needs" (*1967 House Hearings* 118).[27] See generally App., *infra*, 1a-4a. In January 1965, there were 21 states that paid less than 75% of the standard of need established for a family of four under the state's AFDC program. *1967 House Hearings* 119.

After extensive study, the House Committee reported out a substantially revised bill. H.R. 12080, 90th Cong., 1st Sess. (1967); see 113 Cong. Rec. 23048 (1967) (remarks of Rep. Mills).[28] The House Committee rejected the administration's proposal to require the states to pay 100% of the standard of need established under the categorical assistance pro-

---

[27] See also *1967 House Hearings* 184; *Jefferson* v. *Hackney*, 406 U.S. 535, 537 & n.3 (1972); *Dandridge* v. *Williams*, 397 U.S. 471, 481 & n.13, 483 n.15 (1970).

[28] H.R. 12080 is *reprinted in Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess., Pt. 1, 3-209 (1967) ("*1967 Senate Hearings*").

grams. See *Rosado* v. *Wyman*, *supra*, 397 U.S. at 410; see also 45 C.F.R. 233.20(a)(2)(ii), (3)(viii). Nevertheless, Section 220 of the House bill provided that federal financial assistance would be available to the states under the Medicaid program only for expenditures made on behalf of persons whose income, after deduction of medical expenses, was less than 133⅓% of the amount that would be *paid* to a family of the same size under the AFDC program or, in some circumstances, a still lower figure. See *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. On Finance*, 90th Cong., 1st Sess., Pt. 1, 145 (1967) (*"1967 Senate Hearings"*); H.R. Rep. No. 544, 90th Cong., 1st Sess. 5, 18, 118-119, 183 (1967); 113 Cong. Rec. 23055 (1967) (remarks of Rep. Mills). The House Committee specifically noted that AFDC income limits were generally the lowest of all the categorically needy program limits. H.R. Rep. No. 544, *supra*, at 119. Indeed, Representative Mills, Chairman of the House Ways and Means Committee and co-sponsor of H.R. 12080, pointed out that the AFDC standard had been selected precisely "because" it was generally the lowest. See 113 Cong. Rec. 23055 (1967).

In the states that *paid* less than 75% of the AFDC standard of need, therefore, the House provision would have established a spend down level that was even lower than the AFDC standard of need. Since the AFDC standards were generally the lowest, this limitation might have resulted in the denial of Medicaid benefits for the categorically needy as well as the medically needy. See generally App., *infra*, 1a-4a. The House bill did not, however, modify Section 1902(a)(10)(A) of the Act (42 U.S.C. (1970 ed.) 1396a(a)(10)(A)), which required participating states to provide Medicaid benefits to the categorically needy. Hence, although the spend down pro-

vision did not expressly exempt the categorically needy, it seems to have been intended to apply only to the medically needy. See H.R. Rep. No. 544, *supra*, at 118-119; 113 Cong. Rec. 23055 (1967) (remarks of Rep. Mills) ("The proposal in the committee's bill sets two limits on Federal financial participation with respect to the income level States may establish in determining who is medically needy insofar as Federal participation is concerned"); see also *id.* at 23131 (remarks of Rep. Farbstein), 23092 (remarks of Rep. Burton). Indeed, the provision was described in the Senate Committee report as "limit[ing] the persons classifiable as 'medically indigent'" (S. Rep. No. 744, *supra*, at 176).

The limitation on federal participation in the Medicaid program was, as the district court noted (J.S. App. 13a), "but one small part of a Social Security bill containing wide-ranging revisions in several programs." It was recognized, however, as a very significant provision and was severely criticized on the House floor.[29] Indeed, Representative Burton criti-

---

[29] See 113 Cong. Rec. 23065 (1967) (remarks of Rep. King) ("too restrictive"); *id.* at 23077 (remarks of Rep. Burke) ("regressive and * * * primitive"); *id.* at 23082 (remarks of Rep. Vanik) ("I do not believe that we can limit our responsibilities to the unfortunate, needy people of America simply by placing a formula in effect which provides a dollar limitation."); *id.* at 23083 (remarks of Rep. Gilbert) ("inequitable and * * * shortsighted"; "penalizes productive members of the community"); *id.* at 23084 (remarks of Rep. Bingham) ("backward step and a most unfortunate development"); *id.* at 23087 (remarks of Rep. Halpern) (describing impact in New York); *id.* at 23092 (remarks of Rep. Burton) ("contrary to the original title XIX legislative intent"); *id.* at 23093 (remarks of Rep. Ryan) ("a step backward"); *id.* at 23104 (remarks of Rep. Bingham) ("sad spectacle

cized the provision on policy grounds that are virtually indistinguishable from those that underlie the district court's decision in this case (113 Cong. Rec. 23092 (1967)):

> Under the proposed title XIX income limitation we have people drawing old-age security benefits [OASDI]—whose income [after deduction of medical expenses] is less than someone drawing old-age assistance, and they would be precluded —under the clear language of this bill—from getting equivalent medical care that is received by their better-off counterparts on OAA [now SSI]. I do not think that is a thoughtful legislative product.

Representative Burton challenged "anyone to take issue with those statements" (*ibid.*). No one did because the statements were factually accurate. Representative Farbstein criticized the provision on similar grounds (113 Cong. Rec. 23131 (1967)):

> The new income restrictions placed on eligibility for the medicaid program are a tragedy.

---

of using Federal requirements and restrictions to downgrade State programs and reduce their effectiveness"); *id.* at 23125 (remarks of Rep. Boland) (expressing hope "that the Senate will * * * eliminate 133⅓ percent" limitation); *id.* at 23128 (remarks of Rep. Kastenmeier) ("only place[s] the burden on * * * [the] States"); *id.* at 23131 (remarks of Rep. Farbstein) ("new income restrictions * * * are a tragedy"); see also *id.* at 22781 (remarks of Rep. Bingham) ("dismayed by the amendments * * * which represent a major step backward"); *id.* at 22784 (remarks of Rep. Gilbert) ("unfair[]"); *ibid.* (remarks of Rep. Ottinger) ("drastic limitation on medicaid"); *id.* at 22785 (remarks of Rep. Tiernan) ("ill considered and heartless"); *ibid.* (remarks of Rep. Scheuer) ("force[s] many States * * * to take up the slack out of their own pockets"); *ibid.* (remarks of Rep. St. Germain) ("arbitrary and unfair").

> Many working persons who are unable to meet the high cost of medical expenses, many of them now productive members of society, may have to go on welfare in order to receive medical assistance. The new income restrictions will not penalize welfare recipients, but will penalize the self-supporting worker. * * *
>
> I vigorously oppose this amendment to the Medicare [*sic*] Act as being shortsighted and not attuned to the need of our poor population.

See also 113 Cong. Rec. 23083 (1967) (remarks of Rep. Gilbert).

Nonetheless, supporters of the bill specifically defended the spend-down provision,[30] and despite the protestations of Representative Burton and Farbstein, H.R. 12080 was passed by the House and sent to the Senate.

2. The House bill was referred to the Senate Finance Committee. Wilbur Cohen, Undersecretary of Health, Education, and Welfare, testified before the Committee and recommended that the administration's proposal for limiting federal participation in the Medicaid program (*i.e.*, 150% of the highest categorical assistance standard of need) be adopted

---

[30] For example, Representative Mills explained (113 Cong. Rec. 23093 (1967)): "It is only because of what we walked into with this program that the committee has seen fit to put limits on it. * * * I do not think it is fair to tax people through the general funds of the Treasury to pay for the medical costs of those who undoubtedly have the means to buy insurance and to defray their own medical costs." See also 113 Cong. Rec. 23061-23062 (1967) (remarks of Rep. Byrnes); *id.* at 23084-23085 (remarks of Rep. Hanley); *id.* at 23090 (remarks of Rep. Stratton); *id.* at 23091 (remarks of Rep. McCarthy); *id.* at 23105 (remarks of Rep. Taft); *id.* at 22783 (remarks of Rep. Quillen).

in lieu of the House proposal. *1967 Senate Hearings* 282. In urging rejection of the 133⅓% AFDC payment standard, Cohen pointed out that, in states such as Indiana and Texas, 133⅓% of the AFDC payment amount was less than even the AFDC standard of need, and therefore might result in exclusion of some of the categorically needy,[31] a result that he suggested probably was not intended. See *1967 Senate Hearings* 280 (Indiana), 282 (Texas).[32] See

---

[31] As noted above, while the House spend down provision did not expressly distinguish between the categorically needy and the medically needy, it did not modify Section 1902(a)(10)(A) of the Act, which required the states to provide Medicaid to the categorically needy. Cohen's statement that the limitation on federal financial assistance might result in the exclusion of some of the categorically needy may have been based on the notion that the states would not be required to make Medicaid expenditures on behalf of persons for whom federal reimbursement arguably was not available. See *Harris* v. *McRae*, *supra*, 448 U.S. at 308-311.

[32] The district court dismissed Cohen's testimony as immaterial, stating (J.S. App. 13a-14a n.16; citation omitted):

> Undersecretary Cohen did point out that the four-thirds rule [*i.e.*, 133⅓% of the AFDC payment amount] would in some states force a spend-down below the cash assistance level. But he was not testifying about the medically needy-categorically needy discrepancy. The Undersecretary's complaint was that the four-thirds rule would, due to the vagaries of state AFDC programs, exclude some of the categorically needy from Medicaid coverage.

The court offered no explanation of how the Senate Finance Committee could have listened to Cohen "point out that the four-thirds rule would in some states force a spend-down below the cash assistance level" and nevertheless remain unaware that the proposed spend down provision would in some states require the medically needy to incur medical expenses that would reduce their income below the categori-

also App., *infra*, 1a-4a. Furthermore, in connection with the administration's proposal that H.R. 12080 be amended to require the states to pay 100% of the standard of need established under the categorical assistance programs, Cohen emphasized that many states failed to pay 100% of the standard of need under the AFDC program. *1967 Senate Hearings* 259. In January 1967, there were 19 jurisdictions that paid less than 75% of the standard of need established under their AFDC programs. *Id.* at 289; App., *infra*, 1a-4a. In contrast, only 16 jurisdictions paid less than 100% of the standard of need established under their OAA programs. *Ibid.* More important, because of the diffeernces between the standards applicable to AFDC applicants and OAA applicants in January 1967, there were 28 states in which 133⅓% of the AFDC payment amount for one person would have been less than the OAA standard for one person; six of these 28 states had medically needy programs in 1967. See App., *infra*, 1a-4a.

Senator Robert Kennedy also testified before the Senate Finance Committee and urged rejection of the 133⅓% AFDC payment standard. Senator Kennedy specifically pointed out that the House provision would result in medically needy spend down levels that were lower than the standards of need estab-

---

cally needy level. There is no explanation. Moreover, after explaining (*1967 Senate Hearings* 279) that the House bill would "severely restrict the future development of the program," Cohen prefaced his remarks concerning the AFDC payment levels with this statement (*id.* at 280; emphasis added): "What is worse, Mr. Chairman, is the way the House limitation will destroy the concept of *medical indigence* in a number of States." That Cohen chose to make his point in the strongest fashion by focusing on the possible exclusion of some of the categorically needy hardly supports the district court's assertion that his testimony is irrelevant to this case.

lished for the categorically needy (*1967 Senate Hearings* 784; emphasis added):

> [I]nstead of looking to a State's definition of minimum need, [the House bill] looks to the amount which the State actually pays its public assistance recipients. *Title XIX intended that medical indigency be defined at a level substantially in excess of a State's public assistance definition of minimum need. The House bill will in many States have the opposite effect*, and is therefore, totally unrealistic.

Senator Kennedy cited Mississippi and Ohio as examples of states in which this would occur. *Ibid.* See also App., *infra*, 3a-4a.

Following these hearings, the Senate Committee rejected both the House standard and the administration-proposed standard, adopting instead a completely different formula for limiting federal expenditures under the Medicaid program. Under the Senate proposal, participating states would not receive federal financial assistance for Medicaid expenditures made on behalf of any person whose income—presumably, after deduction of medical expenses—was greater than 150% of the OAA cash assistance standard. Since the OAA standard was generally the highest of the cash assistance standards (see 113 Cong. Rec. 33170 (1967) (remarks of Sen. Long)), the Senate limitation, like the administration's proposal, would have had no effect on the Medicaid eligibility of the categorically needy in most states.

In addition, the Senate Committee bill would have established different methods for calculating the federal share of Medicaid expenditures on behalf of the medically needy and the categorically needy. Effective July 1, 1969, the federal share of expenditures

for the medically needy was to be determined by "squaring" the percentage of the state expenditures for the categorically needy paid by the federal government. S. Rep. No. 744, *supra*, at 176-177, 178 (Table B). "Thus, States whose Federal medical assistance percentage is 50 percent under present law would, under the committee bill, receive only 25 percent Federal matching toward the costs of the medically needy." *Id.* at 177. It is difficult to determine precisely what the impact of the Senate bill would have been if it had been adopted. See 113 Cong. Rec. 33168 (1967) (remarks of Sen. Javits) (expressing the view that states would eliminate programs for the medically needy). It is plain, however, that the Senate Committee proposal was intended to discourage participating states from extending coverage to the medically needy. See S. Rep. No. 744, *supra*, at 176-177; see generally 113 Cong. Rec. 33170, 33171 (1967) (remarks of Sen. Long).

On the floor of the Senate, Senator Kuchel offered an amendment to the Committee bill that would have substituted the administration-sponsored limitation on federal financial participation (*i.e.*, 150% of the highest categorical assistance standard of need) and consequently would have eliminated the squaring provision. See 113 Cong. Rec. 32845-32846 (1967) (remarks of Sen. Kuchel). Urging acceptance of the Kuchel amendment, Senator Javits, one of the cosponsors of the amendment (113 Cong. Rec. 33167 (1967)), vigorously criticized the Committee bill on the ground that it discriminated against the medically needy. See 113 Cong. Rec. 33168, 33169 (1967). Senator Long responded (*id.* at 33169): "We are talking here about the people who are not on the cash public assistance rolls. That is the area in which we think

savings should be made." Senator Long acknowledged that the bill discriminated against the medically needy (*ibid.*) but explained (*id.* at 33171): "The committee bill encourages the State to concentrate its medical assistance for those who are most in need, those who qualify for public welfare assistance." Thus, contrary to the implication of the district court opinion (J.S. App. 17a) and appellees' contentions (Mot. to Aff. 20), the Senate rejected Senator Javits' policy arguments opposing discrimination against the medically needy when it rejected the Kuchel amendment. See 113 Cong. Rec. 33174 (1967).[33]

3. After conference, the House 133⅓% AFDC payment standard was adopted, *with an express exception for the categorically needy.* H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. 63 (1967). During the House debates on the Conference Report, several congressmen reiterated their opposition to the AFDC payment standard.[34] In the Senate, one of the con-

---

[33] According to appellees (Mot. to Aff. 20), "the history of the Senate reimbursement provision shows that where Congress did perceive discrimination it acted to eliminate it." Appellees apparently contend that since the Senate provision was not ultimately enacted, Congress must not have intended to discriminate against the medically needy in adopting the 133⅓% limitation. But the Senate reimbursement provision was not enacted because the provision at issue in this case, which is by its terms applicable to the medically needy and not the categorically needy, was enacted in its place. Furthermore, as noted in the text, the Senate rejected the Kuchel amendment and passed the Committee bill, including the provision that "was designed to disfavor the medically needy" (Mot. to Aff. 18).

[34] See 113 Cong. Rec. 36380 (1967) (remarks of Rep. Burton; emphasis added) ("The cutbacks and severe limitation on the income permitted persons entitled to medical care

ferees described the conference committee compromise, specifically noting (113 Cong. Rec. 36319 (1967)) that "no person in any State who was receiving cash welfare benefits will be denied medicaid." See also *Summary of Social Security Amendments of 1967, reprinted in* 113 Cong. Rec. 36312 (1967) ("Federal matching for medical care for all those who are receiving * * * cash assistance * * * will not be affected * * *"). Senator Kennedy complained that the 133⅓% AFDC payment limitation would result in a medically needy spend down level of about $80 per month for a family of four in Mississippi. 113 Cong. Rec. 36784 (1967). More specifically, Senator Mondale quoted Undersecretary Cohen's testimony before the Finance Committee, indicating that in both Indiana and Texas 133⅓% of the AFDC payment amount would be less than the standard of need established under even the AFDC program. *Id.* at 36819. Nevertheless, Congress ap-

---

under title XIX will result in hundreds of thousands of the Nations *medically indigent* being denied needed medical care or in * * * shifting * * * the financial burden to * * * State and local taxpayers"); *id.* at 36381 (remarks of Rep. Gilbert) (penalizes "New York * * * for being responsible"); *id.* at 36385 (remarks of Rep. Reid) ("by substantially reducing the levels of Federal contributions * * * will cast into jeopardy the lives and well-being of our poor and disadvantaged"); *id.* at 36387 (remarks of Rep. Ryan) ("actions of both the House and the Senate with respect to title XIX were devastating to a program which for the first time made hospital and medical care available to people who are medically needy but not welfare recipients"); *id.* at 36389 (remarks of Rep. Farbstein) ("Ironically, the wording of this provision penalizes most severely those persons who are trying hardest to support themselves but remain on the margin of the subsistence point in their incomes").

proved the conference report and enacted Section 1903(f) (42 U.S.C. 1396b(f)) into law.

4. As the foregoing summary of the legislative history clearly demonstrates, Section 1903(f) was motivated by a compelling need to limit federal Medicaid expenditures and was the product of a difficult and hard-fought political compromise. The income limitation that Congress ultimately adopted had been repeatedly criticized on the ground that it was too low. Information before Congress plainly showed that in 28 states 133⅓% of the AFDC payment amount for one person would be less than the Medicaid income limits applicable to the aged categorically needy (*i.e.*, recipients of OAA assistance). Six of these 28 states had medically needy programs in January 1967. Nevertheless, Congress responded by applying the new limitation to the medically needy but not to the categorically needy.

In light of this evidence, appellees' contention that Congress was unaware that the medically needy spend down level established by Section 1903(f) would sometimes be less than the income limitations applicable to the categorically needy is wholly unpersuasive. Appellees' argument "amount[s] to the claim that had Congress been more careful, and had it fully thought out the relationship among the various sections, it might have acted differently." *Maine* v. *Thiboutot*, *supra*, 448 U.S. at 8 (footnote omitted). Such arguments, however, should be addressed to Congress, which can amend the statute if it agrees with appellees' policy concerns.[35]

---

[35] Congress has already declined at least four opportunities to remedy the "discrimination" of which appellees complain. In 1969, four bills to repeal the 133⅓% AFDC payment

C. Section 1903(f) of the Social Security Act is valid under well-settled principles of equal protection analysis

1. Consistent with the equal protection component of the Due Process Clause of the Fifth Amendment, Congress may "treat different classes of persons in different ways" (*Reed* v. *Reed*, 404 U.S. 71, 75 (1971)). See, *e.g.*, *Johnson* v. *Robison*, *supra*, 415 U.S. at 374. When, as in this case, the "statutory classification does not itself impinge on a right or liberty protected by the Constitution, the validity of [the] classification must be sustained unless 'the clas-

---

standard were introduced. H.R. 618, 91st Cong., 1st Sess. (1969) (introduced at 115 Cong. Rec. 69 (1969)); H.R. 1352, 91st Cong., 1st Sess. (1969) (introduced at 115 Cong. Rec. 85 (1969)); H.R. 3272, 91st Cong., 1st Sess. (1969) (introduced at 115 Cong. Rec. 652 (1969)); H.R. 8283, 91st Cong., 1st Sess. (1969) (introduced at 115 Cong. Rec. 5382 (1969)). None of those bills was even reported out of committee. See R. Stevens & R. Stevens, *Welfare Medicine in America: A Case Study of Medicaid* 148, 155 n.88 (1974).

More recently, the Senate adopted a provision that would have required

> any State which extends Title XIX services to the medically needy * * * [to] provide for a *medical assistance standard* [*i.e.*, spend down level] *which is no lower than the payment standard for the related cash assistance program.* The limitation under current law, whereby Federal matching is only available for services provided to persons whose income (after medical expenses) is no higher than 133 percent of the AFDC payment, adjusted for family size, would be overridden but only in those cases where the cash assistance standard for the appropriate recipient category exceeded 133 percent of the adjusted AFDC level.

H.R. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added). The provision was deleted in conference. *Ibid.* See also note 38, *infra*.

sification rests on grounds wholly irrelevant to the achievement of [any legitimate governmental] objective'." *Harris* v. *McRae, supra,* 448 U.S. at 322, quoting *McGowan* v. *Maryland,* 366 U.S. 420, 425 (1961). See, *e.g., Schweiker* v. *Wilson, supra,* 450 U.S. at 230; *Vance* v. *Bradley,* 440 U.S. 93, 97 (1979). The only question is "whether Congress achieved its purpose in a patently arbitrary or irrational way." *United States Railroad Retirement Board* v. *Fritz, supra,* 449 U.S. at 177.

Moreover, in considering equal protection challenges to public assistance legislation, "broad legislative classification[s] must be judged by reference to characteristics typical of the affected classes rather than by focusing on selected, atypical examples." *Califano* v. *Jobst, supra,* 434 U.S. at 55. See, *e.g., Califano* v. *Boles,* 443 U.S. 282, 293 (1979); *Mathews* v. *De Castro,* 429 U.S. 181, 185 (1976); *Dandridge* v. *Williams,* 397 U.S. 471, 486 & n.20 (1970). The constitutional requirement of equal protection accords Congress and state legislatures "wide[] latitude in choosing among competing demands for limited public funds." *Maher* v. *Roe,* 432 U.S. 464, 479 (1977). See, *e.g., Schweiker* v. *Wilson, supra,* 450 U.S. at 238; *Califano* v. *Torres,* 435 U.S. 1, 5 (1978); *Idaho Department of Employment* v. *Smith,* 434 U.S. 100, 101 (1977). This is so because "[a]warding this type of benefits inevitably involves the kind of line-drawing that will leave some comparably needy person outside the favored circle" (*Schweiker* v. *Wilson, supra,* 450 U.S. at 238) and because the policy judgments implicit in such "line-drawing" are matters "for legislative, rather than judicial, consideration." *United States Railroad Retirement Board* v. *Fritz, supra,* 449 U.S. at 179.

2. Measured against these standards, Section 1903(f) clearly passes constitutional muster. "The Constitution imposes no obligation on the [government] to pay * * * any of the medical expenses of indigents" (*Maher* v. *Roe, supra,* 432 U.S. at 469). In a program intended to provide medical assistance for the needy, gross income is plainly one reasonable basis for classification. See *Fullington* v. *Shea, supra,* in which this Court summarily affirmed the rejection of an equal protection challenge to Colorado's decision to provide Medicaid benefits to the categorically needy but not to the medically needy.

At the relevant time—*before* medical expenses are incurred—the categorically needy and the medically needy are not similarly situated. Accordingly, Congress' decision to prescribe different kinds of standards for determining the Medicaid eligibility of individuals in the two groups unquestionably is reasonable. In 1967, when Section 1903(f) was enacted, Congress was confronted with a pressing need to reduce federal expenditures in the Medicaid program. Congress deliberately chose to meet this problem by limiting federal expenditures on behalf of the medically needy rather than limiting expenditures on behalf of the categorically needy. Compare *Jefferson* v. *Hackney, supra,* 406 U.S. at 549; *Dandridge* v. *Williams, supra,* 397 U.S. at 479, 487. Since the medically needy have more income than the categorically needy, they are as a group better able to provide for their own medical expenses—by purchasing insurance or otherwise—than the categorically needy. Congress determined to concentrate limited funds where the need was thought to be greatest. See *Schweiker* v. *Wilson, supra,* 450 U.S. at 238-239; *Califano* v. *Boles, supra,* 443 U.S. at 296; *Fullington* v. *Shea, supra.*

It may be true, as the district court observed (J.S. App. 11a), that Congress could have rationally established a maximum spend down level for the medically needy equal to the relevant cash assistance income limitation. See note 35, *supra*; note 38, *infra*. It does not follow, however, that the *only* rational spend down level is equal to the income limitations prescribed for the categorically needy. That Congress could have accomplished its goal in other ways is simply beside the point. See, *e.g.*, *Schweiker* v. *Wilson*, *supra*, 450 U.S. at 234; *Vance* v. *Bradley*, *supra*, 440 U.S. at 103 n.20; *Cleland* v. *National College of Business*, 435 U.S. 213, 220-221 (1978).[37] By the same token, the fact that one might reasonably maintain that persons such as appellees "with long histories of paying Social Security taxes" are no less deserving than the categorically needy is constitutionally irrelevant. Congress has expressed a different policy judgment in making the categorically needy eligible for Medicaid without more, while requiring the medically needy, including OASDI recipients, to incur a certain amount of medical expenses before qualifying for medical assistance.

So long as the goal is legitimate and the means chosen to effect it are not irrational, Congress' judgment must be sustained. " 'The Constitution presumes that, absent some reason to infer antipathy, even improvident decisions will eventually be rectified by the democratic process and that judicial intervention is generally unwarranted no matter how un-

---

[36] As we have previously explained (see pages 21-22, *supra*), a spend down level is significantly different from an income limitation, and there is no necessary relationship between the two kinds of limitations, particularly in the Medicaid context.

[37] Of course, the district court's proposal would have required a greater expenditure of federal funds than the proposal adopted by Congress.

wisely we may think a political branch has acted.'" *United States Railroad Retirement Board* v. *Fritz*, *supra*, 449 U.S. at 179 n.12, quoting *Vance* v. *Bradley*, *supra*, 440 U.S. at 97.[38]

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted.

REX E. LEE
Solicitor General
J. PAUL MCGRATH
Assistant Attorney General
KENNETH S. GELLER
Deputy Solicitor General
GEORGE W. JONES
Assistant to the Solicitor General
WILLIAM KANTER
BRUCE G. FORREST
Attorneys

JUAN A. DEL REAL
General Counsel
LYNNE K. ZUSMAN
Deputy General Counsel
ROBERT P. JAYE
Acting Assistant General Counsel
DAVID R. SMITH
NANCY S. NEMON
Attorneys
Department of Health and Human Services

DECEMBER 1981

---

[38] Indeed, on October 21, 1981, Representative Frank of Massachusetts introduced a bill that, if enacted, would eliminate the "discrimination" challenged by the appellees. See H.R. 4819, 97th Cong., 1st Sess. (1981). The bill would establish the pertinent combined SSI-state supplementary payment income limits as the spend down level for the aged, blind, or disabled medically needy. No action has been taken on the bill.

Appendix

APPENDIX *

States	I 133 1/3% AFDC Std. of Need for One Person	II Percentage AFDC Std. of Need Paid	III Med. Needy Std. for One Person **	IV OAA Std. of Need for One Person	V Percentage OAA Std. of Need Paid
1. California	*1600*	*86*	*1379*	*1866*	*100*
2. Connecticut	1900	100	1900	1466	100
3. Delaware	*1500*	*79.2*	*1190*	*1333*	*93.5*
4. Hawaii	1800	100	1800	1333	100
5. Illinois	1400	100	1400	1133	100
6. Iowa	*1200*	*75*	*902*	*1200*	*92*

* The information in this appendix is derived from S.Rep. No. 744, 90th Cong., 1st Sess. 178-179, Table C. (1967) and the charts in *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th *Cong.*, 1st Sess., Pt. 1, 289 (1967).

** The medically needy income standard for each state was calculated as follows:

(1) The figure in column one was divided by 1.33 to determine the AFDC standard of need for one person;

(2) The standard of need for one person was then multiplied by the figure in column two to determine the highest amount that would be paid to a single person under the state AFDC program; and

(3) The highest amount that would be paid to a single person under the state AFDC program was multiplied by 133⅓% to determine the medically needy income standard.

States	I 133 1/3% AFDC Std. of Need for One Person	II Percentage AFDC Std. of Need Paid	III Med. Needy Std. for One Person **	IV OAA Std. of Need for One Person	V Percentage OAA Std. of Need Paid
7. Kansas	1900	100	1900	1266	100
8. Kentucky	1400	86.5	1214	1066	100
9. Maryland	1400	100	1400	1066	100
10. Massachusetts	2200	100	2200	1666	100
11. Michigan	*1500*	*82.5*	*1240*	*1333*	*100*
12. Minnesota	1800	100	1800	1200	100
13. Nebraska	*1000*	*41.6*	*417*	*1400*	*94.8*
14. New Hampshire	1700	100	1700	1266	100
15. New York	2000	100	2000	1600	100
16. North Dakota	1600	100	1600	1466	100
17. Oklahoma	1400	100	1400	1400	100
18. Pennsylvania	1600	100	1600	1200	100
19. Rhode Island	*1500*	*100*	*1500*	*1533*	*100*
20. Utah	1500	100	1500	1066	100
21. Washington	1700	100	1700	1600	100
22. Wisconsin	1800	74.1	1337	1200	85
STATES WITHOUT MEDICALLY NEEDY COVERAGE IN 1967					
1. Georgia	*1000*	*63.1*	*632*	*1000*	*88.9*
2. Idaho	1700	100	1700	1333	100

	I	II	III	IV	V
3. *Louisiana*	*1000*	*71.7*	*718*	*1533*	*72.4*
4. *Maine*	*1100*	*56.4*	*621*	*1400*	*100*
5. *Missouri*	*800*	*41.7*	*334*	*1600*	*77.3*
6. Montana	1800	100	1800	1333	100
7. *Nevada*	*1100*	*48.4*	*533*	*1666*	*100*
8. New Mexico	1500	95	1428	1333	100
9. *Ohio*	*1500*	*76.7*	*1153*	*1400*	*100*
10. Oregon	1600	97.2	1559	1200	100
11. *South Dakota*	*1600*	*80*	*1283*	*1466*	*100*
12. *Texas*	*800*	*56.7*	*454*	*1000*	*100*
13. *Vermont*	*1200*	*66.8*	*803*	*1466*	*100*
14. *West Virginia*	*1400*	*74.1*	*1039*	*1600*	*85*
15. *Wyoming*	*1600*	*83.2*	*1334*	*1600*	*75.8* *
STATES WITHOUT MEDICAID PROGRAMS IN 1967					
1. *Alabama*	*500*	*31.7*	*158*	*1533*	*62*
2. *Alaska*	*900*	*43.1*	*388*	*2666*	*49.8*
3. *Arizona*	*900*	*48.6*	*438*	*1333*	*85*
4. *Arkansas*	*700*	*61.1*	*428*	*1333*	*100*
5. *Colorado*	*1100*	*75*	*827*	*1466*	*100*
6. District of Columbia	1300	100	1300	1200	100

* Because Wyoming only paid 75.8% of the Old Age Assistance standard of need, the medically needy standard is less than the OAA standard but greater than the OAA payments.

	States	I 133 1/3% AFDC Std. of Need for One Person	II Percentage AFDC Std. of Need Paid	III Med. Needy Std. for One Person **	IV OAA Std. of Need for One Person	V Percentage OAA Std. of Need Paid
7.	*Florida*	*500*	*28.1*	*140*	*1333*	*67.6*
8.	*Indiana*	*900*	*38.0*	*342*	*1533*	*63.7*
9.	*Mississippi*	*400*	*22.8*	*91*	*1200*	*55.4*
10.	New Jersey	2000	100	2000	1666	100
11.	North Carolina	1200	100	1200	1133	100
12.	*South Carolina*	*500*	*32.4*	*162*	*933*	*100*
13.	*Tennessee*	*900*	*53*	*478*	*1133*	*97.8*
14.	*Virginia*	*1300*	*90*	*1172*	*1400*	*100*

* U. S. GOVERNMENT PRINTING OFFICE: 1961 O - 716 - 33884

Appellee's Brief

1

FILED
JAN 22 1982
ALEXANDER L. STEVAS
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-213

RICHARD SCHWEIKER
SECRETARY OF HEALTH AND
HUMAN SERVICES, APPELLANT,

vs.

GEORGE HOGAN, ET AL.,
APPELLEES

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BRIEF FOR THE APPELLEES

WILLIAM H. SIMON
Stanford Law School
Stanford, California 94305
(415) 497-3627
Court-appointed Counsel for Appellees

Of Counsel:

LUCIEN WULSIN
National Health Law Program
2639 La Cienega Blvd.
Los Angeles, California 90034

MARK COVEN
Greater Boston Elderly Legal
Services
106 Norway St.
Boston, Massachusetts 02115

GARY BELLOW
Legal Services Institute
3529 Washington St.
Jamaica Plain, Massachusetts
02130

GILL DEFORD
National Senior Citizens
Law Center
1636 N. 8th Street
Los Angeles, California 90017

QUESTIONS PRESENTED

I Whether Title XIX of the Social Security Act permits or requires a state to apply in its Medical Assistance program less favorable income eligibility standards to aged and disabled Social Security recipients who are not eligible for Supplemental Security income than it applies to aged and disabled Supplemental Security Income recipients.

II If yes, then whether the Equal Protection requirements of the Fifth and Fourteenth Amendments permit Congress to authorize or require and Massachusetts to apply in its Medical Assistance program less favorable income eligibility standards to aged and disabled Social Security recipients who are not eligible for Supplemental Security income than it applies to aged and disabled Supplemental Security Income recipients.

TABLE OF CONTENTS

Page

Statutes and Regulations Involved 1

Statement 1

Massachusetts' Differing Need Standards 1

Legislative and Administrative Background 2

Introduction and Summary of Argument 7

Argument 12

I. THE DISCRIMINATION VIOLATES THE ACT 12

A. Congress did not intend the discrimination 12

1. The 1967 amendments did not modify the income comparability requirement 12

2. The inconsistency of the comparability and four-thirds rules is the inadvertent result of a last minute attempt to remedy an unrelated problem 16

Background: The New York program 16

The income limitation before conference 18

The income limitation after conference 23

The discriminatory reimbursement provision 24

3. Significance of the legislative history 26

B. The District Court's decision should be upheld on statutory grounds 30

II. THE DISCRIMINATION IS NOT MINIMALLY RATIONAL 34

A. The District Court correctly defined the classification 37

B. There is no rational basis for the classification 41
1. Private insurance 42
2. Medicare 47

CONCLUSION 49

APPENDIX A 1a

APPENDIX B 3a

APPENDIX C 5a

APPENDIX D 8a

APPENDIX E 10a

APPENDIX F 12a

TABLE OF AUTHORITIES

Cases: *Page*

Aitchison v. *Berger*
404 F. Supp. 1137 (S.D.N.Y. 1975) 9,13,34

Bacon v. *Toia,*
648 F. 2d 801 (2d Cir. 1981) 42

Beltran v. *Myers,*
101 S. Ct. 1961 (1981) 13

Boles v. *Califano,*
443 U.S. 282 (1979) 38

Brown v. *Beal,*
404 F. Supp. 770 (E.D. Pa. 1975) 13,34

Cass v. *United States,*
417 U.S. 72 (1924) 30,31

Caldwell v. *Blum,*
621 F. 2d 291 (2d Cir. 1980) 13

Califano v. *Jobst*,
434 U.S. 47 (1977) ..... *passim*

Califano v. *Westcott*,
443 U.S. 76 (1979) 11,37

Clark v. *Uebersee Finanz-Korp*,
332 U.S. 480 (1947) 29

Consumer Product Safety Commission v. *GTE Sylvania, Inc.*, 100 S. Ct. 2051 (1980) 32

Craig v. *Boren*,
429 U.S. 190 (1976) 35

Dandridge v. *Williams*,
397 U.S. 471 (1970) 42

Fabula v. *Buck*,
598 F. 2d 869 (4th Cir. 1979) 13

Flemming v. *Nestor*,
363 U.S. 603 (1960) 10

Fullilove v. *Klutznick*,
100 S. Ct. 2758 (1980) 36

Fullington v. *Shea*,
320 F. Supp. 500 (D. Col. 1970) 38

Hagans v. *Lavine*,
415 U.S. 528 (1974) 37

Harris v. *McRae*,
448 U.S. 297 (1980) 10,11

International Association of Machinists v. *Street*,
367 U.S. 740 (1961) 34

Jefferson v. *Hackney*,
406 U.S. 535 (1972) 18,41

Kassell v. *Consolidated Freightways Corp.*,
101 S. Ct. 1309 (1981) 35

Kent v. *Dulles*,
357 U.S. 166 (1958) 34

Lindsey v. *Normet*,
405 U.S. 56 (1972) 36,48

Lynch v. *Overholser*,
369 U.S. 705 (1962) 31,34

Memorial Hospital v. *Maricopa County*
415 U.S. 250 (1974) 37

Morales v. *Minter*,
393 F. Supp. 88 (D. Mass. 1975) 37

Muniz v. *Hoffman*,
422 U.S. 454 (1975) 30,31

National Labor Relations Board v. *Catholic Bishop of Chicago*,
440 U.S. 490 (1978) 34

O'Brien v. *Skinner*,
414 U.S. 524 (1974) 36

Richardson v. *Belcher*,
404 U.S. 78 (1973) 38

Rinaldi v. *Yeager*,
384 U.S. 305 (1969) 36,37

Rosado v. *Wyman*,
397 U.S. 397 (1970) 18

Schweiker v. *Grey Panthers*,
101 S. Ct. 2633 (1981) 29

Schweiker v. *Wilson*,
101 S. Ct. 1074 (1981) 35,26

Shaak v. *Schmidt*,
344 F. Supp. 99 (E.D. Wis. 1971) 13

Shapiro v. *Thompson*,
394 U.S. 641 (1969) 11,37

Speiser v. *Randall*,
374 U.S. 513 (1958) 36

Tidewater Oil Co. v. *United States*,
409 U.S. 151 (1972) 32

Transcontinental & Western Air, Inc. v.
CAB, 336 U.S. 601 (1949) 32

United Low Income, Inc. v. *Fisher*,
470 F.2d 1094 (1st Cir. 1972) 37

U.S. Railroad Retirement Board v. *Fritz*,
101 S. Ct. 453 (1981) ..... *passim*

United States v. *Price*,
361 U.S. 304 (1960) 33

U.S. Dept. of Agriculture v. *Murray*,
413 U.S. 508 (1973) 36

Vance v. *Bradley*,
440 U.S. 93 (1979) 36

Weinberger v. *Salfi*,
422 U.S. 749 (1975) 40

Weinberger v. *Weisenfeld*,
420 U.S. 636 (1975) 38,43

Zuber v. *Allen*,
396 U.S. 168 (1969) 32

Statutes and Regulations

Page

Omnibus Budget Reconciliation Act of 1981,
Pub. L. No. 97-35, Sections 2171-2172 5,14

26 U.S.C. § 3101 et seq. 3

Social Security Act:
Section 1902(a) (17) 10
Title I, 42 U.S.C. §301 et seq. 3
Title II, 42 U.S.C. §401et seq 3
42 U.S.C. §402(a) 3
42 U.S.C. §402(q) (1) 3
42 U.S.C. §414 3
42 U.S.C. §416 3
42 U.S.C. §423 3
Title XIV, 42 U.S.C. §1351 et seq. 3
Title XVI, 42 U.S.C. §1381 et seq. 3
42 U.S.C. §1382 (e) (2) 7
42 U.S.C. §1382c 3
Title XVIII, 42 U.S.C. §1395c et seq. 45
42 U.S.C. §1395i-2 48
42 U.S.C. §1395o 48
42 U.S.C. §1395p (f) 47
42 U.S.C. §1395v 47
Title XIX, 42 U.S.C. §1396 et seq. 4
42 U.S.C. §1396a(a) (10) 4,15
42 U.S.C. §1396a(a) (10) (A) 4
42 U.S.C. §1396a(a) (17) ..... *passim*
42 U.S.C. §1396b 4

[This Page Intentionally Left Blank]

42 U.S.C. §1396b(b) (1) 47
42 U.S.C. §1396b(f) 39
42 U.S.C. §1396d(a) (ii) 4
42 U.S.C. §1396d(a) (iii) 4
42 U.S.C. §1396d(a) (vii) 4

Pub. L. 90-248, 90th Cong., 1st Sess.
(1967) 14
Pub. L. 96-272, 96th Cong., 2d Sess.
(1976) 32
Pub. L. 96-499, 96th Cong., 2d Sess.
(1980) 47
20 C.F.R. §416.2001 et seq. 4
42 C.F.R. §405.210 47
42 C.F.R. §435.121 4
42 C.F.R. §435.210 20
42 C.F.R. §435.230 4
42 C.F.R. §435.301 5
42 C.F.R. §435.310 5
42 C.F.R. §435.320 5
42 C.F.R. §435.510 5
42 C.F.R. §435.520 5
42 C.F.R. §435.540 5
42 C.F.R. §435. 812-814 40
42 C.F.R. §435.831 5,46,48
42 C.F.R. §435.832 39

Mass. G.L. 118E, §1 3,39

California Welfare and Institutions
Code §140053 (b)-(d) 15

Massachusetts Public Assistance Policy Manual,
ch. IV, section B, ¶¶ (d), (e) 39
ch, IV, p. 15, ¶20 40

Miscellaneous:

CCH Medicare and Medicaid Guide 19

Deneberg, *Risk and Insurance* (3d ed. 1974) 43

Feder and Holahan, *Financing Health Care for the Elderly* (Urban Institute 1979) 45,46

Gibson et al, *Age Differences in Health Care Spending*, Social Security Bulletin 3 (1977) 45

Gornick, *Ten Years of Medicare*, Social Security Bulletin 3 (1976) 45

The Income & Resources for the Elderly in 1978, Social Security Bulletin 3 (December 1981) 10

Martin, *Public Assurance of An Adequate Income In Old Age*, 64 Corn. L. Rev. 437 (1979) 7,10

Monaghan, *Foreward: Constitutional Common Law*, 89 Harv. L. Rev. 1 (1975) 36

Mueller, *Private Health Insurance in 1973*, Social Security Bulletin 21 (1975) 45

Myers, *Medicare* (1970) 16,43

Perry, *Modern Equal Protection*, 79 Cal. L. Rev. 1023 (1979) 36

Quarterly Tables, Social Security Bulletin 62 (September 1981) 10

Stevens and Stevens, *Welfare Medicine in America* (1974) 16

U.S. Department of Commerce, Bureau of the Census, Current Population Reports, *Money Income and Poverty Status of Families and Persons in the United States: 1980*, (Series P-60, No. 127, August 1981) 27

U.S. Department of Health, Education and Welfare, *DATA on Medicaid Program* 26 (1979 ed. Rev.) 4,45,46

U.S. Department of Health and Human Services, Medical Assistance Manual §4-30-30 ..... *passim*

Urban Systems Research and Engineering, *AFDC Standards of Need* (1980) 28

Blue Cross & Other Private Health Insurance for the Elderly: Hearings before the Subcommittee on the Health of the Elderly, 89th Cong., 2d Sess., (1964) 45

Medical Care for the Aged: Hearings Before the Committee on Ways & Means, 89th Cong., 1st Sess. (1965) 45

President's Proposal for Revisions in the Social Security System: Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess., (1967) 16

Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Committee on Finance, 90th Cong., 1st Sess. (1967) 18,21

Conf. Com. Rep. No. 1030, reprinted U.S. Code Cong. and Ad. News, 90th Cong., 1st Sess. (1967) 22

113 Cong. Rec. (1967):

p. 22783 16
p. 23055 21
p. 23062 16,17
p. 23084 16
p. 23091 ..... *passim*
p. 23092 20
p. 23093 17
p. 23124 16
p. 32450 19
p. 32592 25

p. 33166-74 16
p. 33167 21,25
p. 33168 25
p. 33170 21
p. 33171 25
p. 35918 29
p. 36303 29
p. 36784 22,29
p. 36819 22
p. 36924 29

125 Cong. Rec. (1979):
p. 15150, 15153 33

127 Cong. Rec. (1981):
p. H5804 15
p. H5813 15
p. S9281 15

46 Fed. Reg. 47976 (1981) 5
46 Fed. Reg. 47987 (1981) 15

H.R. 4819, 97th Cong., 1st Sess. (1981) 33

H.R. 5710, 90th Cong., 1st Sess. (1967) 14,17

H.R. 12080, 90th Cong., 1st Sess. (1967) 14,17,23

H. Rep. No. 544, 90th Cong., 1st Sess. (1967) ..... *passim*

H. Rep. No. 92-1605, 92nd Cong., 2d Sess. (1972) 33

H. Rep. No. 97-208, 97th Cong., 1st Sess. (1981) 14

S. Rep. No. 404, 89th Cong., 1st Sess. (1965) ..... *passim*

S. Rep. No. 744, 90th Cong., 1st Sess. (1967) 19,21

S. Rep. No. 94-1265, 94th Cong., 2d Sess. (1976) 33

STATUTES AND REGULATIONS INVOLVED

The Massachusetts Medical Assistance and Supplemental Security Income financial eligibility standards as of the time of the decision below appear at Jt. App. 25-28; the current standards appear in Appendix A hereto. Section 1903(f) of the Social Security Act ("the Act"), 42 U.S.C. 1396b(f) ("the four-thirds rule"), appears at J. S. App. 30a-32a. Section 1902(a) (17) of the Act, 42 U.S.C. §1396a(a) (17) ("the comparability rule"), appears in Appendix B hereto.

STATEMENT

Massachusetts Differing Need Standards. Although this case arises from a complicated nexus of government programs, its central focus is a distinction in the Massachusetts Medical Assistance ("Medicaid") program which can be simply described: Massachusetts provides Medicaid to aged and disabled cash public assistance recipients and to the aged and disabled self-supporting. Yet it applies different standards of need to them. These standards determine the amount of income an applicant may retain for non-medical needs while qualifying for Medicaid coverage of medical expenses. The standards Massachusetts applies to the self-supporting allow them far less income than the standards the state applies to public assistance recipients. Although the public assistance standards represent the state's estimate of a subsistence budget for the aged and disabled, the standards applied to the self-supporting are as much as $185 per month below the public assistance standards.

The impact of the different standards is illustrated by the situation of the representative appellees. George Hunter is 70 years old; he is a double amputee confined to a wheelchair. George Hogan is 63 years old; he has a large surgically-made

cavity in his chest as a result of treatment for tuberculosis. They can live outside a medical institution only with the help of continuous and extensive medical treatment which they can only obtain with Medicaid. Prior to retirement, Mr. Hunter worked and paid Social Security taxes for more than 30 years, and Mr. Hogan did so for more than 25 years. Because of their past work and contributions, they and their wives are entitled to sufficient Social Security income to make them self-supporting. If the Hunters were public assistance recipients, the Massachusetts Medicaid program would allow them to retain $611.32 per month for their non-medical needs, but because of their Social Security income, the program allows them to retain only $425. If the Hogans were public assistance recipients, Massachusetts would allow them to retain $599.83 per month for their non-medical needs; because of their Social Security income, it allows them only $425.[1] Jt. App. at 33-34; Dist. Ct. Opinion (hereinafter "Opinion"), J.S. App. at 4a-8a.

Legislative and Administrative Background. This case involves three programs in the system of income maintenance established by the Social Security Act: Old Age, Survivors, and Disability Insurance (OASDI or Social Security); Supplemental Security Income (SSI); and Medicaid.

Social Security is the basic social insurance program established by Title II of the Act in 1935 to provide income security for the aged and disabled and their survivors and dependents.

---

[1] These are the standards currently in effect. See Appendix A hereto. The standards in effect at the time of the District Court's decision are set out at pp. 23-28 of the Joint Appendix. The disparity between the public assistance and self-supporting standards has increased since the decision below.

The reason for the difference in the figures with respect to the Hunters and the Hogans is that the public assistance standards are slightly different for couples such as the Hunters with two aged (over 65) members than for couples such as the Hogans with one disabled and one aged member.

Primary entitlement depends on attainment of age 65 (or for reduced benefits, age 62), 42 U.S.C. 402(a), (q) (1) and (9), or on disability, 42 U.S.C. 416(i), 423. Social Security is a contributory program; benefits are financed by taxes which workers and employers are required to pay, and eligiblity also depends on having engaged in a requisite amount of employment covered by the tax. See 42 U.S.C. 414; 26 U.S.C. 3101 *et seq.*

SSI is the federal public assistance program for the aged and disabled established by Title XVI of the Act in 1972. It is the successor to the Old Age Assistance and Aid to the Permanently and Totally Disabled programs originally established by Titles I and XIV of the Act in 1935. As for Social Security, eligibility for SSI depends on attainment of age 65 or on disability, which is defined identically to the Social Security definition. 42 U.S.C. §1382c(a)(1) and (3). Unlike Social Security, however, SSI payments are not based on recipients' work history or tax payments. SSI eligibility depends on financial need. An aged or disabled person or couple with income and resources below the financial eligibility standards is eligible to receive an SSI payment sufficient to bring its income up to the standards. Aged and disabled Social Security recipients with income below the SSI standards are entitled to both Social Security and SSI.

Basic SSI income standards are established by Congress, but states have the option (and in some instances, the obligation) to raise these standards by supplementary payments. See 42 U.S.C. §1382(c). Massachusetts law provides for the supplementation of SSI payment standards "based on need" as determined by the Department of Public Welfare. Mass. G.L.C. 118E, §1. The state supplements are added to the federal standards to determine the Massachusetts SSI income and payment standards. Both federal and state supplementary payments are administered through a single application and

payment process by the same agency which administers Social Security, the Social Security Administration. See 20 C.F.R. §416.2001 *et seq.*

Medicaid is a cooperative federal-state program established by Title XIX of the Act in 1965 which pays for the cost of medical treatment for people whose income is insufficient to meet their needs. Medicaid is administered by the states under plans formulated by them but subject to federal statutory and regulatory requirements. The states are reimbursed by the federal government for a percentage of their expenses. 42 U.S.C. 1396b. Title XIX gives states a variety of options with respect to Medicaid coverage. The most general classes of eligibility are called "categorically needy" and "medically needy." The categorically needy consist primarily of those eligible to receive cash assistance under the two principal cash public assistance programs of the Act, Aid to Families with Dependent Children (AFDC) and SSI. 42 U.S.C. 1396a(a) (10) (A). A Medicaid program must cover all AFDC recipients and at least some SSI recipients, 42 C.F.R. 435.120-35, 435.230; Massachusetts and a majority of other states cover all SSI (including state supplement) recipients. U.S. Department of Health, Education, and Welfare, *Data on the Medicaid Program* 26 (1979 ed. rev.) Thus, an aged or disabled SSI recipient in Massachusetts receives a cash grant based on the state's estimate of his non-medical needs plus full Medicaid coverage.

The medically needy include those who meet the categorical eligibility requirements of the cash assistance programs (that is family dependence (AFDC) or age or disability (SSI), but who cannot receive cash assistance because their gross income and resources exceed the financial eligibility requirements of those programs. 42 U.S.C. 1396a(a) (10) (C); 1396d(a) (ii), (iii), (vii); as amended Omnibus Budget and Reconciliation Act of 1981 (Pub. L. 97-35), sections 2171-72; 42 C.F.R. 435.301,

310, 320, 510, 520, 540, as amended 46 Fed. Reg. 47976 (Sept. 30, 1981).[2] Title XIX makes medically needy coverage optional; Massachusetts covers medically needy dependent families and the medically needy aged and disabled.

The financial eligibility standards for medically needy coverage are designed to take account of the impact of medical expenses on an applicant's financial situation; accordingly they measure income net of medical expenses. As with SSI and categorically needy coverage, medically needy financial eligibility is determined by standards based on a subsistence budget for non-medical needs, or as the Medical Assistance Manual puts it, "the basic maintenance needs of the individual or family." Department of Health and Human Services, Medical Assistance Manual, §4-30-30, ¶ (B) (1), p. 5 reprinted Appendix C hereto. To the extent that the applicant's income exceeds the standard, he or she must use the "surplus" for medical expenses. When the applicant has incurred expenses on his or her own account which reduce his or her income below the standards, he or she is eligible for Medicaid for subsequent medical expenses during the relevant eligibility period. 42 C.F.R. 435.831; Opinion, J. S. at 6a-7a. In the jargon of the program, the medically needy may establish eligibility by "spending down" for medical expenses the amount by which their income exceeds the eligibility standards.

Thus, Massachusetts allows both the categorically and medically needy aged and disabled a basic amount for non-medical needs plus Medicaid coverage for medical needs. The categorically needy retain all their income (any non-SSI income and an SSI grant sufficient to raise their income to the SSI income

[2]Since the lower court's decision, Title XIX has been extensively revised by the Omnibus Budget and Reconciliation Act of 1981. However, none of the changes affects the substance of the eligibility features at issue in this case. See n. 8, *infra*.

standards) and receive Medicaid. The medically needy retain an amount of income equal to the medically needy standards (after incurring medical expenses in an amount sufficient to lower their income to these standards) and receive Medicaid. The SSI/categorically needy standards and the medically needy standards each determine the amount of income for non-medical expenses left to the aged and disabled people to whom they apply. Title XIX required that the medically needy income standards be "comparable" to the corresponding categorically needy income standards. 42 U.S.C. 1396a(a) (17).

This case arises from the fact that Massachusetts applies much less favorable income standards to the medically needy aged and disabled than to SSI recipients. It forces aged and disabled Social Security recipients who are not eligible for SSI to reduce their incomes by as much as $185 per month below the amount it has determined to be necessary for the basic non-medical needs of the aged and disabled and which it guarantees SSI recipients.

The only basis asserted for Massachusetts' different income standards is a 1967 amendment to Title XIX which Massachusetts and the Secretary of Health and Human Services ("the Secretary") interpret to require discrimination against the medically needy under the circumstances of the Massachusetts program. The amendment permits a state to provide Medicaid to the categorically needy in accordance with its cash assistance standards but prescribes a maximum for medically needy standards of 133 1/3 percent ("four-thirds") of a state's maximum AFDC payments. 42 U.S.C. 1396b(f). Because in Massachusetts four-thirds of the AFDC standards is below the SSI standards, the four-thirds maximum produces discrimination against the medically needy aged and disabled. Massachusetts and the Secretary interpret the four-thirds amendment to create an implied exception to the requirement of 42 U.S.C. 1396a(a)

(17) that medically needy standards be "comparable" to corresponding categorically needy standards.[3]

INTRODUCTION AND SUMMARY OF ARGUMENT

The challenge to the classification involved in this case is unusual because of two distinctive features of the complex of Social Security Act programs from which it arises. The first is what Professor Martin has called "a historically unique degree of institutional parallelism." *Public Assurance of An Adequate Income In Old Age*, 64 Corn. L. Rev. 437, 445 (1979). The public assistance program created by Title XVI of the Social Security Act incorporates the same criteria of categorical eligibility (that is, of age and disability) used in the social insurance program created by Title II, and the Medical Assistance program created by Title XIX in turn incorporates these same criteria. The second feature is a procedure designed to achieve equity between public assistance recipients and people who, although they have more gross income, are in fact at least as needy because of medical expenses. This procedure is the medically needy or "spend down" feature of Title XIX, which was specifically enacted to remedy what Congress considered

[3]Because of the less favorable income standards, medically needy Social Security recipients would be much better off if they could forego their Social Security income in order to qualify for SSI and categorically needy Medicaid coverage. For example, at the time of the decision below, the named appellee George Hunter's income exceeded the SSI eligibility standard by 92 cents. Because of this excess, he was forced to spend down by nearly $100 per month in order to qualify for the Medicaid he needs. Opinion at 5a-6a. Thus, less than a dollar in Social Security income cost him nearly $100 per month. However, the Act requires people in the situation of the appellees to apply for and accept all income for which they are eligible. 42 U.S.C. 1382(e)(2).

"one of the weaknesses identified" under predecessor programs:

> [Some programs] contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the state plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of medical care needed . . . . S. Rep. No. 404, reprinted in U.S. Code Cong. and Ad. News, 89th Cong., 1st Sess., 2019 (1965).

To remedy this situation, Congress required that in medically needy programs income be "measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires." *Id.*

In this context, the distinction made in the Massachusetts Medicaid program, which applies separate and far more stringent financial eligibility criteria to Social Security recipients in the position of the appellees than it applies to identically situated SSI recipients, is uniquely arbitrary. For example, this is not a case in which a "broad legislative classification" based on "characteristics typical of the affected classes" merely fails to include some "atypical examples." *Compare Califano* v. *Jobst,* 434 U.S. 47, 55 (1977). On the contrary, *every* member of the appellee class is identically situated in terms of the identical criteria of age and disability to the favored class of SSI recipients and has been so identified by the same bureaucracy which administers the SSI program, the Social Security Administration.

Nor is this a case, such as *Fullington* v. *Shea,* 320 F. Supp. 500 (D. Col. 1970), *Aff'd* 404 U.S. 963 (1971), in which a class is disfavored because the state has decided not to consider some

factor bearing on its situation. Unlike Medicaid programs such as the one involved in *Fullington* which do not cover the medically needy and which therefore consider eligibility only on the basis of gross income without reference to medical expenses, the Massachusetts program does cover the medically needy, and the entire premise of the medically needy option is to require determination of eligibility in terms of income relative to medical expenses. Yet, having established a program which necessarily identifies the self-supporting aged and disabled who are identically situated to SSI recipients, Massachusetts applies a separate standard which deprives them of basic medical care and/or a substantial portion of the subsistence income the state provides aged and disabled SSI recipients.

The arbitrariness of this discrimination is striking, not only because its effect is to deprive the appellees of income and medical benefits needed for basic subsistence, but because the effective difference between the favored and disfavored classes is that the members of the latter have worked, saved, and made Social Security contributions sufficiently to become self-supporting in old age and disability. As Judge Frankel wrote in holding invalid a provision in the New York Medicaid program discriminating against the medically needy:

> [I]t remains deep and familiar in our esteem for individual initiative that we would not deem it acceptable without some particular justification to treat those outside categorical assistance groups less generously than those within. *Aitchison* v. *Berger,* 404 F. Supp. 1137, 1149 (S.D.N.Y. 1975), *aff'd* 538 F.2d 307 (2d Cir.), *cert. denied,* 429 U.S. 890 (1976).

Moreover, the Medicaid program is designed as an integral part of the income maintenance system of which Social Security is the foundation. Yet, Massachusetts' different eligibility standards are radically inconsistent with the equities expressed throughout "the entire legislative scheme [which] rests on the

legislative judgment that those who in their productive years were functioning members of the economy may justly call on that economy in their later years." *Flemming* v. *Nestor*, 363 U.S. 603, 610 (1960). *See Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 645 (1975) (discrimination against women Social Security contributors "more pernicious" than other sex-based discrimination because "in this case Social Security taxes were deducted from [appellee's] salary during the years in which she worked").[4]

In Part I, we show that the interpretation of Title XIX most consistent with legislative history and applicable principles of construction prohibits the discrimination against the appellees.[5] The "comparability" requirement of section 1902(a) (17) was enacted in 1965 specifically to prohibit a state from setting medically needy income standards below the standards of the corresponding categorical groups. That requirement was not

---

[4]The class of aged Social Security recipients is almost co-extensive with the class of all aged people. In 1979, 92.5 percent of the population aged 65 or over received Social Security. Perhaps as much as an additional five percent were eligible for it but had not yet retired. *Quarterly Tables*, Social Security Bulletin 62 (Sept. 1981); *The Income and Resources of the Elderly in 1978*, Social Security Bulletin 3,5 (Dec. 1981). Social Security accounts for more than a quarter of the total income of the aged. Martin, *supra* at 451.

[5]The statutory basis was not pressed below. However, to the extent that the constitutional analysis begins with legislative history, it is entwined with the issue of statutory interpretation. In the course of preparing this appeal, the appellees have realized that many of the factors emphasized by the Court below — the absence of actual legislative purpose for the discrimination, Congress' failure to alter the comparability requirements, and the equal treatment problem — support equally rulings on statutory and constitutional grounds. Thus, in accordance with the Court's policy that statutory bases of decision be considered before constitutional questions are reached, e.g., *Harris* v. *McRae*, 448 U.S. 297, 307-8 (1980), we urge the statutory grounds here.

altered in 1967 at the time of the enactment of the four-thirds eligibility maximum. The background of the four-thirds rule shows that its surface inconsistency with the comparability requirement is a remote result of a last minute change in conference — which was never discussed — designed to deal with an unrelated problem. The Secretary's argument that Congress was aware that the four-thirds rule would require discrimination against the medically needy is based on a distorted and misleading account of the legislative history. Indeed, it was literally impossible for anyone to have been aware of this result throughout most of the history to which the Secretary refers. Fairly read, the legislative history shows that Congress did not intend that the four-thirds rule abridge the comparability requirement.

Although the legislative history supports both appellees' statutory and constitutional claims, the constitutional claims do not depend on any interpretation of legislative history. The District Court did not base its decision on statutory grounds. After determining that there was no actual Congressional purpose served by the classification, the lower court proceeded to consider the purposes which the Secretary suggested below, and concluded that the statutory classification is not rationally related even to these hypothetical purposes. Thus, as we show in Part II, the classification cannot withstand equal protection analysis even under the most limited standard of review.[6]

---

[6]The District Court held unconstitutional both the Massachusetts Medicaid standards and the four-thirds rule to the extent that it makes the discrimination against the medically needy a condition of federal reimbursement. Jt. App. at 6. Although the four-thirds rule is styled as a limitation on federal reimbursement, it is tantamount to a direct restriction on eligibility, since Title XIX does not contemplate that a state provide benefits for which federal reimbursement is not available. *Harris* v. *McRae*, 448 U.S. 297, 309 (1980). The Constitution prohibits Congress from conditioning federal payments on state practices which deny equal protection. *Califano* v. *Westcott*, 443 U.S. 76 (1979); *Shapiro* v. *Thompson*, 394 U.S. 618, 641 (1969).

ARGUMENT

I.

THE DISCRIMINATION VIOLATES THE ACT.

Congress did not recognize when it enacted the four-thirds rule in 1967 that, because a state's old age assistance standards might be higher than four-thirds of its AFDC standards, the four-thirds maximum might conflict with the comparability requirement, and it did not intend that the maximum abridge the comparability requirement. Accordingly, the comparability provision, not the four-thirds rule, controls this case, and the decision below should be affirmed on statutory grounds.

A. Congress did not intend the discrimination.

1. The 1967 amendments did not modify the income comparability requirement.

A fundamental Congressional purpose in the creation of the medically needy feature of Title XIX was to achieve equity between public assistance recipients and others similarly situated. S. Rep. No. 404, *supra* at 2019. The requirement of 42 U.S.C. 1396a(a) (17) that income standards be "comparable for all groups" is an expression of this commitment.[7] There is

[7]Subsection (a)(17) provides an exception to the income comparability requirement which is not relevant here. The exception authorizes differing eligibility standards within the medically needy group "in accordance with standards prescribed by the Secretary . . . based on variations between shelter costs in urban areas and in rural areas." The Medical Assistance Manual permits shelter cost variations in limited circumstances. Section 4-30-30, p. 10, ¶5, Appendix C. The Massachusetts standards make no distinctions based on such variations.

no dispute that the income comparability requirement was enacted to prohibit a state from setting its medically needy standards below the corresponding cash assistance standards. The 1965 legislative history is explicit on this point:

> The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however . . . may a State require the use of income or resources which would bring the individual's income below the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State to be as necessary for his maintenance. S. Rep. No. 404, *supra* at 2019.

The federal courts consistently have interpreted the comparability requirement to prohibit less favorable eligibility criteria for the medically needy than for corresponding categorically needy groups. *Aitchison* v. *Berger,* 404 F. Supp. 1137 (S.D.N.Y. 1975), *aff'd* 538 F. 2d 307 (2d Cir.), *cert. denied* 429 U.S. 890 (1976); *Brown* v. *Beal,* 404 F. Supp. 770 (E.D. Pa. 1975); *Caldwell* v. *Blum,* 621 F.2d 491 (2d Cir. 1980), *cert. denied,* 49 L.W. 3894 (1981); *Schaak* v. *Schmidt,* 344 F. Supp. 99 (E.D. Wis. 1971); *Fabula* v. *Buck,* 598 F.2d 869 (4th Cir. 1979); see *Beltran* v. *Myers,* 101 S. Ct. 1961, 1963-64 (1981) (Stevens, J., concurring).

The issue between the parties is whether the 1967 amendment to the federal reimbursement provisions of Title XIX which imposed the four-thirds maximum was intended to create an exception to the income comparability requirement when comparability would require medically needy standards above the four-thirds maximum. The previous cases interpreting the income comparability requirement have not involved this issue

because in all of them comparability could be achieved without exceeding the four-thirds maximum.[8]

---

[8]The Medicaid amendments of the Omnibus Budget and Reconciliation Act of 1981 eliminated some further statutory requirements of comparable treatment which are not involved in this case. The eliminated requirements prescribed comparable treatment of the different categorical groups (aged, disabled, families) within the categorically and medically needy classes. As a result of the amendments, the aged may now be treated differently from the disabled and either may be treated differently from families. *See* Pub. L. No. 97-35, section 2171; H. Rep. No. 97-208, 97th Cong., 1st Sess., at Title XXI, section 15. The legislative history is explicit that the 1981 amendments do not alter the comparability requirement involved in this case: the requirement that the income standards applicable to each medically needy group be comparable to those applied to the corresponding categorical group. 127 Cong. Rec. H 5804, H 5813, S 9218 (July 31, August 3, 1981) (Remarks of sub-conference co-chairman Rep. Dingell and Sen. Dole and of Rep. Waxman quoting sentence inadvertently omitted from conference report).

While the statutory mandate with respect to income comparability between the medically and categorically needy has remained unchanged since 1965, the Secretary's position has been inconsistent. Prior to last fall, the Secretary's regulations required that the medically needy standards be no lower than the categorically needy standards except where the four-thirds maximum was lower, in which case the regulations required standards at the maximum. 42 C.F.R. 435.812-814 (1980). However, in some instances, the Secretary has permitted of standards which exceed the four-thirds maximum in order to achieve comparability. A provision of the Health Care Financing Administration Regional Office Manual transmitted in 1979 acknowledges that the maximum based on four-thirds of the AFDC standards is unrelated to any reasonable estimate of the needs of medically needy adults and states that a state may exceed the four-thirds maximum for medically needy couples "in the interest of comparable treatment of people with similar needs." The provision appears in CCH Medicare and Medicaid Guide, § 30,393, at 9521-22, and is excerpted in Appendix E hereto. Moreover, the Secretary has allowed the California Medicaid plan to employ an income disregard which has the effect of raising the medically needy standards for the aged and disabled above the four-thirds maximum in

Congress's treatment of the comparability language of Title XIX at the time of enactment of the four-thirds rule shows that it did not intend to alter the income comparability requirement. In 1967, Title XIX contained, in addition to the requirement of comparable income standards for the medically and categorically needy, another comparability requirement which prescribed that comparable services be provided to the different groups (aged, disabled, and families) within the categorically and medically needy classes. The 1967 amendments did not alter the unqualified language of the statute requiring income comparability. But, in connection with a provision of the 1967 amendment unrelated to the four-thirds rule which Congress intended to modify the service comparability requirement, it amended that requirement to make its intention explicit.

The exception appeared as section 223(a) at every stage of the legislative history under the heading "Modification of Comparability Provisions." H.R. 5710; H. R. 12080 (House and Senate versions); Pub. L. 90-248, 90th Cong., 1st Sess. (1967). It was the only change made in the comparability provisions. The inference is thus inescapable that the only modification of the comparability requirements Congress in-

---

(footnote continued from preceding page)
order to achieve comparability with the California SSI standards. *See* California Welfare and Institutions Code § 14005.3(b)-(d).

The regulations recently promulgated by the Secretary in response to the 1981 amendments prescribe that medically needy standards be no lower than those for the corresponding categorically needy group, but suggest that exceptions may be permitted, in addition to when the four-thirds maximum is lower, when the Secretary specifically approves the lower standard upon a showing by the state of a "reasonable" basis for the distinction between categorically and medically needy. 42 C.F.R. § 435.812, as amended 46 Fed. Reg. 47987 (Sept. 30, 1981). Although this additional departure from comparability is unauthorized by the statute, it is not involved in this case. Massachusetts and the Secretary suggest no basis for the distinction at issue here other than the four-thirds maximum.

tended to make in 1967 was the express modification made to accommodate the Medicare provision. The income comparability requirement specifically used the word "comparable" and in 1967 this requirement appeared in the same subsection, 42 U.S.C. 1396a(a) (10), as the service comparability requirement Congress amended. See 42 U.S.C. §1396(a) (10) (C) (1974). If Congress had understood that any provision of the 1967 amendments would modify the income comparability requirements, it would have so indicated in the "Modification of Comparability Provisions" section of the Act, just as it did with the service comparability requirement.

2. The inconsistency of the comparability and four-thirds rules is the inadvertent result of a last minute change made to remedy an unrelated problem.

The legislative history of the four-thirds rule confirms the inference which arises from Congress's failure to amend the income comparability requirement. This history is complex, but it is not ambiguous. Fairly and carefully read, it compels the conclusion that Congress did not contemplate that the four-thirds maximum would require medically needy standards below the corresponding categorically needy standards.

Background: The New York Program. Congress was prompted to consider eligibility limitations in 1967 in reaction to the New York Medicaid program, which had set its eligibility standards "in or close to an average income range." H. Rep. No. 544, 90th Cong., 1st Sess. 118 (1967). The New York Department of Social Welfare had calculated that the New York standards made 45 percent of the entire state eligible for Medicaid on the basis of gross income (that is, in addition to those who might qualify by spending down). R. Stevens and R. Stevens, *Welfare Medicine in America* 92, 103, n.4 (1974);

testimony before the Ways and Means Committee put the estimate at between 40 and 45 percent statewide and as high as 79 percent in some counties. *President's Proposal for Revision of the Social Security System: Hearings on H. R. 5710 Before the House Committee on Ways and Means*, 90th Cong., 1st Sess. 603, 1953 (1967); *see* 113 Cong. Rec. 23091 (1967) (Remarks of Rep. Stratton); *see generally* R. Myers, *Medicare* 288-94 (1970). The New York standards were repeatedly mentioned throughout the legislative history as exemplifying the situation to which the eligibility limitations were addressed.[9]

Although members of Congress expected the income eligibility limitation to have a substantial, even drastic, impact on the New York medically needy program, that impact was seen as the elimination of recipients "in or close to an average income range," H. Rep. No. 544, at 118, and "those who could not reasonably be classified as medically indigent" from the medically needy program. 113 Cong. Rec. 23062 (Rep. Byrnes). Supporters of the bill characterized the purpose of the eligibility maximum as to "bring . . .this legislation into line with our original intent" by precluding the unexpectedly high New York standards and denied that "any of the basic purposes of Title XIX [would be] harmed or injured in any way." *Id.* at 23091 (Rep. Stratton); *id.* at 23093 (Rep. Mills); *id.* at 23062 (Rep. Byrnes).

---

[9]See, *e.g.*, 113 Cong. Rec. 23124 (Rep. Robison: "It was the New York pl[illegible]hat precipitated committee action in this respect"); *id.* at 23084 (Rep. Hanley: "The State of New York . . . moved quickly to show us the error of our ways"); *id.* at 22783 (Rep. Quillen: "the Medicaid act . . . is amended to remove the problem pointed up last year by events in New York"); *id.* at 33168 (Sen. Javits: "efforts of Congress to correct what New York did"). Of the 31 citations offered on pp. 28-30 of the Secretary's brief as representative of the floor debates, 23 are to statements either made by New York congressmen or specifically referring to the New York program.

The income limitation before Conference. Three versions of the income eligibility limitation were introduced and considered. H. R. 5710, §220; H. R. 12080, §220; H. R. 12080, [Senate version] §220. From the perspective of the present case, the most important feature of the three versions is that none of them distinguished between the categorically and the medically needy. Thus, none of them could have caused the discrimination challenged here. If any of the proposed limitations had been enacted in the form in which it was discussed in Congress up to the time of Conference, the limitation might, in a state which had a medically needy program and where the maximum was below one of the categorical assistance standards, have required spending down below the cash assistance levels. But it would have required *both* cash assistance recipients and the medically needy to spend down to the same level. Since these were the only provisions Congress discussed up to the time of Conference, it was literally impossible up to that point for any Congressman to have anticipated that the eligibility maximum might cause discrimination against the medically needy. Discrimination became possible only when the Conference Committee adopted the House four-thirds maximum but altered it to except the categorically needy. The prior legislative history makes clear that it did so in response to a problem entirely unrelated to the present situation.

This problem was first identified by Undersecretary of Health, Education and Welfare Wilbur Cohen in testimony before the Senate on the House four-thirds version. The House version was 133 1/3 percent of the "highest amount ordinarily paid" to recipients under a state's AFDC program. Undersecretary Cohen considered this language important because some states — he mentioned Indiana and Texas — pay recipients only a fraction of the difference between their countable income and the AFDC eligibility or "need" standards. Because in these

states the payment standards are below the need standards, a person can have countable income in excess of the "highest amount ordinarily paid" and still be eligible to receive some payment (*i.e.*, a payment of some fraction of the difference between income and the need standard). In a few states the gap between the AFDC maximum payment and the AFDC need standards was so great that a Medicaid maximum of 133 1/3 percent of the maximum payment would be less than the AFDC need standards and hence would exclude some AFDC recipients.[10] Undersecretary Cohen thought this result a "drafting oversight." *Social Security Amendments of 1967: Hearings on H. R. 12080 Before the Senate Committee on Finance*, 90th Cong., 1st Sess. 280-82 (1967).

Undersecretary Cohen's point was taken up by others; his examples were repeated, and Mississippi and Ohio were also given as examples of states in which the House version would exclude some of the categorically needy. See *id.* at 784, 1442, 1684 (Statements of Sen. Robert Kennedy; George Meany, and Walter Reuther). It is critical to note that this problem — the problem of Medicaid standards below cash assistance need standards — was perceived and discussed as a problem concerning only the categorically needy. Indeed, none of the only four

[10]For example: A state might have an eligibility or need standard of $200 for a two-person family but pay only 50 percent of "need." The "highest amount ordinarily paid" would be $100, the amount a family with no income would receive. A family with $150 countable income would be $50 below the need standard and, in some states, would receive 50 percent of the deficiency, or $25. If Medicaid eligibility were limited to 133-1/3 of the AFDC payment standard, such a family, though eligible for an AFDC payment (thus categorically needy), would be ineligible for Medicaid because its income ($150), though below the need standard, would be above 133-1/3 percent of the highest amount paid ($133.33). See *Rosado* v. *Wyman*, 397 U.S. 397, 408-09 (1970); *Jefferson* v. *Hackney*, 406 U.S. 535, 539-46 (1972).

states mentioned as examples where the "below need" problem would occur had then or has today a Medicaid program covering the medically needy. S. Rep. No. 744, 90th Cong., 1st Sess. 178 (1967); CCH Medicare and Medicaid Guide ¶¶ 15, 584 (Indiana), 15, 604 (Ohio), 15, 626 (Mississippi) and 15, 644 (Texas). Each state covers only cash assistance recipients in its program.

Since the "below need" problem had not been identified at the time of the initial passage of the House version on August 17, there was no discussion of it in the House debates. Following the Senate hearings in which Undersecretary Cohen and others criticized the House version for creating this problem in states with low AFDC payment ratios, the Senate Finance Committee reported its amended version of the House bill setting the maximum at 150 percent of the Old Age Assistance standards. 113 Cong. Rec. 32450 (Nov. 14, 1967). Although Senators Kuchel and Javits criticized the Senate maximum as too low, and Senator Kuchel unsuccessfully proposed an amendment to raise the maximum to 150 percent of the "highest" cash assistance standard, *id.* at 33166-74, there was no occasion in the Senate for discussion of the "below need" problem, much less of the possibility of discrimination. Neither the Finance Committee version nor Senator Kuchel's alternative distinguished between the categorically and medically needy, and neither was identified as posing (and very likely neither did pose) the "below need" problem.

Only two items of legislative history cited in the appellant's brief even appear to indicate awareness of the possibility of discrimination against the medically needy, and in both instances the appearance is misleading.

First, the appellant quotes at p. 29 from the following remark by Representative Burton during debate on the House version:

> What if one is too proud to take welfare and the com-

> bined social security benefits between husband and wife are a lesser amount than that which they would receive on welfare?
>
> Under the proposed Title XIX income limitation we have people drawing old age security benefits — whose income is less than someone drawing old age assistance and they will be precluded under the clear language of this bill — from getting equivalent medical care that is received by their better-off counterparts on OAA. I do not think that is a thoughtful legislative product. 113 Cong. Rec. 23092.

By omitting the first sentence quoted above and by interpolating the phrase "[after deduction of medical expenses]" following the word "income," the brief makes the language appear to refer to discrimination against the medically needy. But the remark could not possibly refer to that because, as we have explained, the provision Representative Burton was talking about (the pre-conference House version) could not have caused discrimination against the medically needy. Properly quoted, the remark refers to an entirely different issue: the problem of people who want Medicaid and would be eligible for it as categorically needy if they would apply for cash assistance but who are "too proud" to do so (because they view cash assistance as more demeaning than Social Security or Medicaid).[11]

Second, the appellant asserts that "[i]nformation before Congress plainly showed" that in 1967 there were six states with medically needy programs in which the old age standards exceeded the AFDC standards by more than four-thirds (albeit

[11] The Secretary has responded to the problem Representative Burton was talking about by a regulation permitting those who are eligible for cash assistance but have not applied for it to receive Medicaid as categorically needy. 42 C.F.R. 435.210. (It is not clear how Representative Burton thought the income limitation would affect this problem.)

in three of them by only a few dollars a month) and other states without medically needy programs where this was the case. Brief at 37, Appendix. The basis for this statement is an analysis performed by the appellant which takes data from one of 23 pages of charts appended to Undersecretary Cohen's testimony on the House version, combines it with further data in a chart in the Finance Committee report on the Senate version, and then makes adjustments to permit comparison of the Old Age standards and four-thirds of the AFDC standards. The analysis is ingenious,[12] but it is preposterous to assert that the data before Congress "plainly showed" the conclusions the appellant has so elaborately derived in retrospect.[13] Insofar as the record shows, no legislator ever associated the two sets of data or made anything resembling such an analysis.[14]

The bill reported from Conference adopted the House version but with one critical change: it excepted the categorically

---

[12]But there is reason to doubt its reliability. The data in Undersecretary Cohen's chart apply to an AFDC household of four, and the chart specifically indicates that they may not be valid for other units of other sizes, *Social Security Amendments of 1967, supra* at 289; yet the data from the Senate Report apply to one person units. S. Rep. No. 744, at 178-79.

[13]Indeed, it appears that it did not even occur to the appellant that the data might be used in this fashion until we referred to it in our Motion to Affirm. See the Motion at p. 14 and the appellant's Reply Brief.

[14]The only remarks in debate which bear on the ratio of Old Age and AFDC standards suggest only a vague knowledge of them. Thus, Representative Mills referred to the AFDC standards as "generally speaking" the lowest. 113 Cong. Rec. 23055 (August 17, 1967), and Senator Long said, "I believe that in most of the states [the old age standards are] the higher standards." *Id.* at 33170 (November 20, 1967). On the other hand, Senator Kuchel urged that the Senate version be amended to change the maximum from 150 percent of the Old Age standards to 150 percent of the "highest" standards, clearly assuming that the Old Age standards were sometimes not the highest standards. *Id.* at 33167.

needy from the maximum. Conf. Com. Rep. No. 1030, reprinted U.S. Code Cong. and Ad. News, 90th Cong., 1st Sess. 3209 (1967). Although this change had not previously been proposed and was never specifically explained, there is only one explanation for it. It was a response to the "below need" problem identified by Undersecretary Cohen and others designed to insure that some AFDC recipients were not excluded in states with low AFDC payment ratios. This was the first point at which any provision created the possibility of discrimination.

The income limitation after Conference. Thus, the only opportunity Congress had to recognize and approve this discrimination was in the debate on the Conference version. However, the record not only fails to indicate recognition and approval, it shows that those who discussed the provision were not even aware of the Conference change, much less of the consequences it made possible. Senators Kennedy and Mondale were the only legislators to make more than passing reference to the four-thirds rule in debate on the Conference Report. Senator Kennedy began by stating that "the House Medicaid limitation has been adopted," without saying anything about the change made in the House version by the Conference Committee to except the categorically needy. He then argued against the limitation, stating that it would require eligibility levels in Mississippi as low as $80 a month and in Ohio as low as $3,000 a year. 113 Cong. Rec. 36784. Senator Mondale, also referring to the "House bill" without any mention of the change, quoted Undersecretary Cohen's testimony concerning the "below need" effects on eligibility in Indiana and Texas. *Id.* at 36819. These are the states and the figures discussed previously in testimony and debate about the "below need" problem within the categorically needy programs of states with low AFDC payment

ratios. Although the Secretary relies on these remarks as evidence of recognition of the discrimination challenged by the appellees, they in fact show the opposite: The only two Congressmen to discuss the Conference version were not even aware that the bill had been amended to eliminate the "below need" problem within the categorically needy programs they were talking about, and since this was the change which made possible the discrimination against the medically needy, they could not have been aware of that possibility.

The discriminatory reimbursement provision. Although there is no mention of discrimination in the history of the four-thirds rule, Congress did perceive another provision of the Senate bill as discriminating against the medically needy, and its treatment of that provision further confirms that it did not intend or anticipate the discrimination at issue here. The Senate bill would have reduced federal Medicaid expenditures in two ways. The first was the income limitation which, as noted above, did not distinguish between the categorically and medically needy. The second was a reduction in the percentage rate at which the federal government would reimburse state Medicaid expenditures, which applied only to the medically needy. H. R. 12080 [Senate version], Section 220(a) (3). This provision was eliminated from the enacted bill. Congress's rejection of the Senate reimbursement rate provision is highly pertinent because the principal objection expressed to it was precisely that it discriminated against the medically needy. Thus, Senator Javits stated that a limitation on income eligibility was acceptable to New York, but that the less favorable treatment of the medically needy in the reimbursement rate provision was not:

> MR. JAVITS . . . . However the Senate Finance Committee bill discriminates in how much Federal assistance some of those included would receive.

> The essence of our argument is that there is discrimination. The State is induced not to extend medical assistance because they are not drawing cash relief. The Senator [Long] wants to encourage people to go on cash relief. Do not discriminate against them; lower your [income eligibility] limit, if you want; but treat everyone who falls below the ceiling in the same manner. That is the essence of our argument. 113 Cong. Rec. 33171 (Nov. 20, 1967).

Senator Kuchel voiced a similar criticism. *Id.* at 33167-68.

These remarks distinguish between the limit on income standards, which was not understood to discriminate against the medically needy, and the reduction in reimbursement rates, which was deemed objectionable precisely because it did discriminate.[15] Although the Senate declined to adopt the amendment which Senator Kuchel proposed to eliminate the reimbursement provision at the time these remarks were made, the Javits-Kuchel position ultimately prevailed when the Conference Committee rejected the reimbursement provision.

At the least, this episode confirms that the legislators did not recognize that the income limitation might cause discrimination since if there had been such awareness, it would surely have prompted the same criticisms made against the Senate reimbursement provision. Moreover, although Congress's reasons for rejecting the reimbursement provision cannot be conclusively determined,[16] it is significant that it rejected the only

---

[15]The only point in the legislative history at which any legislator spoke in favor of discrimination occurred when Senator Long defended the discriminatory reimbursement provision (not the income limitation), saying "needy persons have first call on Federal funds." 113 Cong. Rec. 32594 (Nov. 20, 1967). The remark obviously lends no support to the appellant's position since, first, it did not refer to the income limitation, and second, the provision it did refer to was rejected by Congress.

[16]The reimbursement provision was also criticized for applying disproportionately to wealthier states. 113 Cong. Rec. 33172-73 (Remarks of Sen. Kuchel).

measure which had been identified as discriminating against the medically needy.

3. Significance of the legislative history

The legislative history is entirely consistent: In 1965 Congress enacted the comparability requirement for the specific purpose of prohibiting a state from setting its medically needy eligibility standards "below the level determined by the state as necessary for [the applicant's] maintenance." S. Rep. No. 404, at 2019. In the course of the 1967 amendments, when witnesses and legislators pointed out that the original House bill would require categorically needy recipients in a few states to spend down below the cash assistance levels, it acted again to prohibit this. And after another provision of the Senate bill was criticized as discriminating against the medically needy, it rejected that provision. Thus, at every point where Congress faced either the "below need" problem or the problem of discrimination, it has taken a position against them.

When the Secretary's misreadings of legislative history are put aside, the argument for Congressional awareness rests only on an inference from the language of the four-thirds rule. The argument is that, since Congress applied the maximum to the medically needy but made an exception for the categorically needy, it must have assumed that the maximum would sometimes require medically needy standards lower than categorically needy standards and therefore must have intended to abrogate the comparability requirement in these circumstances. But the legislative history rebuts this inference and shows why Congress applied the maximum only to the medically needy without anticipating any departure from comparability.

Congress made the exception for the categorically needy for the purpose of rectifying a problem peculiar to the categorically

needy programs for four states which did not have medically needy programs. Comparability is not an issue in such states. Congress's attention was focused on the gap between the AFDC payment and need standards in Indiana, Ohio, Mississippi, and Texas. There was nothing in the nature of this problem to draw its attention to a different analysis — the ratio of Old Age to AFDC standards — in a different group of states -- states with medically needy programs. The legislators adopted the exception for the categorically needy as a way of insuring that AFDC recipients would not be excluded in states with low payment ratios without giving any thought to its possible impact on comparability in medically needy states.

Moreover, attention to the "below need" problem was marginal even within the context of the discussion of the four-thirds rule. For most legislators, the eligibility maximum was merely a response to the excesses of the New York program which was understood to have made nearly half the state eligible by setting its income standards "in or close to an average income range." H. Rep. No. 544, at 118. This understanding and rhetoric hardly suggests the possibility that the maximum might force eligibility standards below the state-defined subsistence level.[17] And in the New York program, the only one extensively

[17]The Massachusetts SSI standards are, of course, far below the middle income range. For example, in 1980, the standards for an aged couple provided for an annual income of (taking account of the mid-year increase) $6,520.10. By contrast, median income nationwide during 1980 for two-person families was $17,189. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, *Money Income and Poverty Status of Families and Persons in the United States: 1980* (Series P-60, No. 127, August 1981) at 7.

discussed, the four-thirds maximum exceeded the Old Age Standards.[18]

The suggestion that Congress was aware of the possibility of discrimination ignores not only the substance of legislative discussion, but the practical realities of the process of legislative revision. Up to the time of the Conference, the only solution proposed for the "below need" problem was raising the eligibility maximum. The possibility of discrimination could not have been recognized until the Conference Committee adopted the solution of excepting the categorically needy. Yet there was almost no opportunity to discover the issue after the Conference version was reported. The Medicaid income limitation was merely one among several amendments designed to restructure the Medicaid program which were in turn part of an omnibus Social Security bill with major changes in all the Social Security Act programs, including Social Security benefits and taxes, Medicare reimbursement practices, Medicaid nursing home coverage and regulation, AFDC reimbursement

---

[18]See the Appendix to the Appellant's brief. According to the Secretary, in six of the 28 states with medically needy programs the Old Age standards exceeded the four-thirds maximum, although in three of them by only a few dollars a month.

If the Secretary's analysis is correct, it indicates that the number of states in which discrimination occurs increased from six to perhaps 15 since 1967. J.S. at 10. The magnitude of the discrimination also appears to have increased. Both increases reflect the widening gap between AFDC and Old Age standards since 1967. In 1974 the Old Age program was renovated into the federal SSI program, and in 1976 Congress provided for automatic increases in the SSI standards in accordance with increases in the cost of living. 42 U.S.C. 1382(f). By contrast, AFDC benefits have not been indexed and have increased more slowly than SSI benefits. *See* Urban Systems Research and Engineering, *AFDC Standards of Need* (Study Prepared for Office of Research and Statistics, Social Security Administration 1980). Thus, the potential for discrimination was much less salient in 1967 than today.

practices, and AFDC work and child care practices. "The Social Security Act is among the most intricate ever drafted by Congress." *Schweiker* v. *Grey Panthers*, 101 S. Ct. 2633, 2640 (1981). Along with Medicare, Medicaid was the newest and most unfamiliar of these programs, and the medically needy or "spend down" part was its most novel and unfamiliar feature. The entire omnibus committee bill was debated in the House on only one day and in the Senate on only two days under a closed rule and enacted within a few days of emerging from committee.[19] Legislators complained in debate that they had had insufficient time to analyze the bill. At the time of the enactment of the bill containing the original version of the four-thirds rule, Representative Mathias stated, "The House has had less than two weeks to consider the committee's proposals and in this short time has not been able to make a full assessment of its import nationally or in individual cities and states." 113 Cong. Rec. 23129 (Aug. 17, 1967). Senator Kennedy made a similar complaint at the time of passage of the Conference bill. *Id.* at 36784 (Dec. 15, 1967). And, as noted in section 2, the remarks of Senators Kennedy and Mondale in debate on the Conference version, which is the only direct evidence of Congress's understanding of the Conference version, show that these legislators, who were among those with the most interest in and knowledge about the four-thirds rule, were not even aware that the critical change had been made. Thus, "[w]e are dealing with hasty legislation which Congress did not stop to perfect as an integrated whole." *Clark* v. *Uebersee Finanz-Korp*, 332 U.S. 480, 488-89 (1947).

Given the complexity of the issues and their context, it is not

---

[19]The Conference bill was reported in the House on December 11 and enacted on December 13. 113 Cong. Rec. 35918, 36342. It was reported in the Senate on December 13 and enacted on December 15. *Id.* at 36303, 36924.

surprising that no legislator undertook the relatively specialized analysis necessary to ascertain the possibility of discrimination. As the Court has emphasized, "[w]e must allow ourselves some recognition of the existence of sheer inadvertence in the legislative process." *Cass* v. *United States*, 417 U.S. 72, 83 (1974).

B. The District Court's decision should be upheld on statutory grounds.

The interpretation of Title XIX required by the approach to statutory analysis established by this Court is that the four-thirds maximum of section 1903(f) does not apply where it would require a departure from the comparability requirement of section 1902(a). Since this interpretation would support entirely the result below, it would obviate the Court's having to reach the constitutional issue.

Read literally and apart from its context and history, the four-thirds rule supports the Secretary's position. But this Court holds that a statutory provision "may not be read apart from other relevant provisions" or "isolated from its legislative history." *Muniz* v. *Hoffman*, 422 U.S. 454, 458 (1975).

> [I]t is not unusual that exceptions to the applicability of a statute's all inclusive language are not contained in the enactment itself but are found in another statute dealing with particular situations to which the first statute might otherwise apply. *Id.*

In such situations, this Court consistently has rejected applications of statutory language which would have the effect of abridging established Congressional policy expressed in related

prior legislation or legislative history where Congress has not indicated an intent to alter the established policy.[20]

Thus, for example, in *Cass* v. *United States*, 417 U.S. 72 (1974), the Court rejected a literal application of language which would make certain military reservists with less than five years of service eligible for readjustment pay when it found no evidence in the legislative history that Congress intended to alter the previously established policy requiring five years service. The Court found it "significant that there is no indication [of how] such a change would affect the goals of the readjustment pay provisions, contrary to the careful attention these matters received when benefits under the readjustment pay statute were raised" in a previous session. *Id.* at 83. And in *Muniz* v. *Hoffman, supra*, despite the "categorical" language in 18 U.S.C. §3692 providing for jury trial in cases growing out of labor disputes, the Court held there was no jury right in contempt proceedings for violations of injunctions under the Taft-Hartley Act where "[n]ot a word was said in [the legislative history of §3692] that would suggest any important change in the settled intention of Congress." *Id.* at 467-68.

See also Lynch v. *Overholser*, 369 U.S. 705, 710-11 (1962) (statute requiring civil commitment of criminal defendants acquitted on grounds of insanity does not apply to a defendant who did not plead insanity, where this interpretation "is more consistent with the general pattern of laws governing the confinement

---

[20]The maxim that where statutory provisions conflict the more specific controls is not helpful here. The comparability rule deals specifically with the issue of whether the medically needy standards can be below the categorically needy standards; the four-thirds rule deals specifically with the issue of how high the medically needy standards can be. The question before the Court is which of the two provisions creates an exception to the other. The question of which is more specific depends on the question of which is more *applicable*. Thus, any attempt to apply the maxim of specificity would be circular.

of the mentally ill [than] a literal reading of the Section"); *Tidewater Oil Co.* v. *United States*, 409 U.S. 151 (1972) (despite its language, interlocutory appeals statute interpreted not to apply to government antitrust cases absent indication of Congressional intent to alter prior conflicting rule of Expediting Act); *Transcontinental & Western Air, Inc.* v. *CAB*, 336 U.S. 601, 604-05 (1949) (provision empowering Civil Aeronautics Board to make "such rates effective from such dates as it shall determine to be proper" interpreted not to apply to retroactive orders absent indication Congress intended "departure from the customary pattern of fixing rates").

While we recognize that the Secretary's interpretation of the provisions at issue in this case is entitled to weight, "it is only one input in the interpretational equation." *Zuber* v. *Allen*, 396 U.S. 168, 193 (1969).[21] The basic issue remains Congressional intent, and all evidence of Congressional intent indicates that Congress did not intend the 1967 amendments to affect the comparability policy of the 1965 provisions.[22]

---

[21] Moreover, the weight is reduced by the fact that the Secretary's interpretation has not been consistent. See n. 8, *supra;* Appendix E.

[22] The post-1967 instances of legislative history cited by Massachusetts and the Secretary as suggesting subsequent Congressional recognition and acceptance of discrimination against the medically needy merely confirm the maxim that " 'the views of a subsequent Congress are a hazardous basis for inferring the intent of an earlier one.' " *Consumer Product Safety Commission* v. *GTE Sylvania, Inc.*, 100 S. Ct. 2051, 2060 (1980).

In one of these instances, the legislative history shows explicitly *lack* of awareness of the discrimination. In 1980 when Congress enacted an amendment permitting recipients to disclaim an increase in veterans' benefits in order to retain SSI and categorically needy Medicaid eligibility, it limited the amendment to states without medically needy programs. Pub. L. 96-272, §310. The amendment's sponsors explained that the provision was unnecessary in medically needy states because there recipients would retain Medicaid eligibil-

(continued)

Moreover, there are further indications outside the specific context of Title XIX that the Secretary's interpretation is untenable. One is the arbitrariness of a rule which would disfavor the self-supporting and penalize work and Social Security contributions. As lower federal courts have recognized in interpreting the comparibility provision, an interpretation which presumes

---

(footnote continued from preceding page)

ity after losing SSI simply by spending down all or part of the increase. Thus, they were unaware that in some medically needy states recipients would have to spend down by more than the increase because medically needy standards were lower than SSI standards. The explicit premise of limiting the amendment to states without medically needy coverage was the assumption that in medically needy states recipients would be no worse off with medically needy than they were with categorically needy coverage. 125 Cong. Rec. 15150 (Oct. 25, 1979) (Remarks of Sen. Cranston); *see also id.* at 15153 (Remarks of Sen. Dole).

The 1976 amendment which preserves Medicaid eligibility for a few people who lose SSI eligibility because of certain Social Security cost-of-living increases also has nothing to do with medically needy discrimination. Like the 1980 veterans' benefit amendment, this one was proposed to protect against "loss of Medicaid" from the increases, S. Rep. No. 94-1265, reprinted U.S. Code Cong. and Ad. News, 94th Cong., 2d Sess. 6022 (1976), which is the result in states without medically needy programs; it was not proposed to deal with less favorable treatment, the result in medically needy states with discriminatory standards.

Other than Representative Frank's bill (H.R. 4819, 97th Cong., 1st Sess.), which was filed in response to this case last fall when Congress was in the midst of a historically unprecedented restructuring of the entire Federal budget and on which no action was taken, the only instance which suggests any legislative recognition of the problem of medically needy discrimination is a 1972 amendment passed by the Senate for the purpose of remedying the discrimination which was not considered in the House and was eliminated without explanation in Conference. H. Rep. No. 92-1605, 92nd Cong., 2d Sess. 61 (1972). "Such non-action by Congress affords the most dubious foundation for drawing references." *United States* v. *Price*, 361 U.S. 304, 311 (1960).

Congressional willingness to disfavor the self-supporting is too far at odds with basic social values and more general legislative commitments to be adopted without compelling and explicit support. *Aitchison* v. *Berger, supra* at 1149 (implausible to suggest Congress intended "to treat those outside categorical assistance groups less generously than those within"); *Brown* v. *Beal*, 404 F. Supp. 770, 773 (E.D. Pa. 1975) (Title XIX should be construed to avoid result which would mean "plaintiff has been penalized for working").

Finally, the interpretation of Title XIX urged here is supported by "the rule that a statute should be interpreted, if fairly possible, in such a way as to free it from not insubstantial constitutional doubts." *Lynch* v. *Overholser*, 369 U.S. 705, 711 (1962); *National Labor Relations Board* v. *Catholic Bishop of Chicago*, 440 U.S. 490, 500 (1978); *International Association of Machinists* v. *Street*, 367 U.S. 740, 749 (1961); *Kent* v. *Dulles*, 357 U.S. 166, 129 (1958). The Court should affirm on the basis of the comparability provision in order to obviate reaching the constitutional issue.

II.

THE DISCRIMINATION IS NOT MINIMALLY RATIONAL.

The court below did not decide this case on statutory grounds, and its equal protection ruling does not rest on any interpretation of legislative history. The court examined the legislative history for evidence of actual congressional purpose, but even after it found none, it proceeded to consider whether the classification might be rationally related to the purposes suggested below by the Secretary. Specifically refusing to apply a standard higher than minimum rationality, the court found that the classification was not rationally related to *any* legitimate

purpose. The decision thus rests on the most limited standard of equal protection review for which there is any support in the decisions of this court.[23]

---

[23] Although it did not do so, we submit that the Court would have been warranted in applying a more demanding standard of review upon determining that the discrimination against the appellees resulted from legislative inadvertence. As this Court acknowledged last term, equal protection doctrine does not definitively indicate whether the same standard of scrutiny applies where the rational basis asserted by the defenders of a statute is "a convenient, but false *post hoc* rationalization," *Craig* v. *Boren*, 429 U.S. 190, 200 n. 7 (1976), as applies where the basis is "Congress deliberate, considered choice." *Schweiker* v. *Wilson*, 101 S. Ct. 1074, 1083 (1981). *Compare Kassel* v. *Consolidated Freightways Corp.*, 101 S. Ct. 1309, 1320–23 (1981) (Brennan, J., concurring) *with id.* at 1332–34 (Rehnquist, J., dissenting); and *U.S. Railroad Retirement Board* v. *Fritz*, 100 S. Ct. 453, 458–60 (1981) (Rehnquist, J.) *with id.* at 463–64 (Brennan, J., dissenting). The Court's recent discussion in *Schweiker* v. *Wilson*, *supra*, leaves the issue open. The majority did not reach the issue because it interpreted the legislative history to show that the classification reflected a "deliberate, considered" Congressional choice. However, its opinion was fully consistent with the premise articulated by Justice Powell in dissent that:

> the Court should receive with some skepticism *post hoc* hypotheses about legislative purpose unsupported by the legislative history. When no indication of legislative purpose appears other than the current position of the Secretary, the Court should require that the classification bear a "fair and substantial relation" to the asserted purpose. *Id.* at 1088.

The present case illustrates the propriety of such a higher than minimal standard.

Where as here the classification at issue is not the product of legislative judgment, the presumption of legislative competence, which arises from the legislature's superior facilities for fact-finding and policy formulation and its ability to represent the will of the electorate, is attenuated. A "false *post hoc* rationalization" can only be based on policy the legislature has not formulated and facts the legislature has not found. When such a rationalization has to be put forth, the legislature has not performed the role contemplated in the constitutional scheme, and there is no legislative decision to defer to.

(continued)

"At the minimum level this Court consistently has required that the legislature classify the persons it affects in a manner rationally related to legitimate governmental objectives." *Schweiker* v. *Wilson,* 101 S. Ct. 1074, 1080 (1981). *See, e.g., Rinaldi* v. *Yeager,* 384 U.S. 305 (1973); *Lindsey* v. *Normet,* 405 U.S. 56, 76-78 (1972); *U.S. Dept. of Agriculture* v. *Murray,* 413 U.S. 508 (1973); *see generally* Perry, *Modern Equal Protection,* 79 Col. L. Rev. 1023, 1072-73 (1979). Although a state may have no obligation to provide a benefit, when it chooses to do so, it may not do so pursuant to arbitrary criteria. *E.g., Lindsey* v. *Normet, supra* at 77; *Speiser* v. *Randall,* 374 U.S. 513, 518-19 (1958); *Sherbert* v. *Verner,* 374 U.S. 398, 404-05 (1958); *O'Brien* v. *Skinner,* 414 U.S. 524 (1974). Thus, although all welfare benefits are constitutionally optional, none is

---

(footnote continued from preceding page)

In this situation, the Court's role should take account of the prior malfunctioning of the constitutional scheme. *See generally Schweiker* v. *Wilson, supra* at 1087–88 (Powell, J., dissenting); *U.S. Railroad Retirement Board* v. *Fritz, supra* at 463–66 (Brennan, J., dissenting); *Fullilove* v. *Klutznick,* 100 S. Ct. 2758, 2811–14 (1980) (Stevens, J., dissenting); *Vance* v. *Bradley,* 440 U.S. 93, 116–24 (1979) (Marshall, J., dissenting).

In applying a higher standard to inadvertent classifications the Court does not substitute its own judgment for the legislature's. Rather it defers to the norms of equal treatment prescribed by the Constitution in the absence of a contrary legislative judgment. Moreover, a decision based on the absence of actual legislative purpose is consistent with deference to the legislature because, unlike a decision striking down a considered legislative classification, it does not preclude subsequent re-enactment of the classification after the legislature has considered it. *See* Monaghan, *Foreward: Constitutional Common Law,* 89 Harv. L. Rev. 1 (1975). What Justice Stevens has called "a more tentative holding of unconstitutionality based on a failure to follow [legislative] procedures," *Fullilove* v. *Klutznick, supra* at 2813, does not limit legislative discretion but merely enforces the Constitutional premise of legislative deliberation.

exempt from the constitutional obligation to draw reasonable distinctions. *See Hagans* v. *Lavine*, 415 U.S. 528, 539 (1974). For example, in *Fritz, supra* at 460, the Court required a rational basis for a distinction in a statute providing "windfall benefits." *Compare United Low Income, Inc.* v. *Fisher*, 470 F.2d 1074 (1st Cir. 1972) (state has no obligation to provide AFDC unemployment coverage) *with Califano* v. *Westcott*, 443 U.S. 76 (1979) (where state provides AFDC unemployment coverage, arbitrary classification denies equal protection.[24]

Moreover, the state "must do more than show that denying [welfare benefits to some] saves money." *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 263 (1974); *Shapiro* v. *Thompson*, 394 U.S. 618, 633 (1969). "Obviously, any measure that cuts benefits conserves public funds." *Morales* v. *Minter*, 393 F. Supp. 88, 100 (D. Mass. 1975). Minimum rationality requires that there be some basis for the "classifying feature" which determines who is to bear the burden of public savings. *Rinaldi* v. *Yeager*, 384 U.S. 305, 309 (1969).

A. The District Court correctly defined the classification.

The class certified by the District Court consists of aged and disabled Social Security recipients who have income which is high enough to make them ineligible for SSI but which, when reduced to account for medical expenses in accordance with the Massachusetts medically needy eligibility regulations, is lower than the SSI income standards. The Secretary appears not to dispute that *this* class is identically situated to SSI recipients. The Secretary's principal argument is that it was improper for

---

[24]The *Westcott* classification was sex-based, but that distinction goes to the *level* of scrutiny, not to whether scrutiny is required.

the Court to define the class disfavored by the Massachusetts Medicaid standards in terms of income net of medical expenses. He argues that the Court should have ignored the net income feature of medically needy coverage and considered the appellees merely a part of the larger class of people with gross income exceeding the SSI standards. Brief at 11-12, 19-20, 40. If the situation could be viewed this way, cases such as *Califano* v. *Jobst, supra,* and *Fullington* v. *Shea, supra,* which hold that welfare programs are not required to classify precisely or consider every factor bearing on need, would support reversal. But the argument does nothing more than re-name the appellee class to suit the Secretary's conclusion. Such tactics should not be mistaken for serious equal protection analysis: "[A] statutory discrimination between two like classes cannot be rationalized by assigning them different labels." *Richardson* v. *Belcher,* 404 U.S. 78, 83 (1972). The District Court defined the classes in the terms which the statutory scheme itself makes relevant; the Secretary's characterization depends on ignoring these factors.

"The proper classification for purposes of equal protection analysis is not an exact science," *Boles* v. *Califano,* 443 U.S. 282, 293-94 (1979), but when the Court has approached the problem in the context of the Social Security Act, it has emphasized two principles. First, "scouting must begin with the statutory classification itself." *Id.* Second, the classification must be defined in a manner consistent with "the context and history" of the relevant statutes. *Weinberger* v. *Weisenfeld,* 420 U.S. 636, 655 (1975) (Rehnquist, J., concurring). In the present case both the statutory language and its history and context require the lower court's definition of the classification.

The plain language of the four-thirds maximum itself defines the class to which it applies in terms of net income:

> In computing a family's income for purposes of [the four-thirds maximum] there shall be excluded any costs

> (whether in the form of insurance premiums of otherwise) incurred by such family for medical care . . .42 U.S.C. 1396b(f) (2).

The most basic premise of the medically needy coverage has always been that income be measured net of medical expenses:

> [B]efore an individual is found ineligible for all or part of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires. S. Rep. No. 404, *supra* at 2019.

The legislative history of the four-thirds rule confirms that the 1967 amendment made no change in this basic premise.

> Provisions of present law under which a family's income is first reduced by the amount of their medical expenses in determining eligibility would be retained. H. Rep. No. 544, *supra* at 119.

And, of course, both federal and state law require that medically needy income eligibility be determined on the basis of net income. 42 C.F.R. 435.832; Massachusetts Public Assistance Policy Manual, Ch. IV, section B, ¶¶ (d), (e), reprinted Jt. App. 29-30.[25] The Secretary's Medical Assistance Manual

---

[25]The appellant's brief argues at pp. 12, 21–23, that the medically needy income standards are "not directly comparable" to the categorically needy standards because the latter also function as the SSI standards. The argument makes no sense, and it contradicts the statute and the position the Secretary has consistently taken heretofore. Both the medically needy and categorically needy standards are explicitly standards of "need." *See* G.L.C. 118E, § 1 (Massachusetts SSI standard "based on need"); Medical Assistance Manual, section 4–30–30, p. 5 ¶ 1(a) ("Medically needy income levels are established . . . to meet the basic maintenance needs of the individual or family.") Each standard functions to determine the amount of income available for non-medical needs to the Medicaid recipients to whom it applies. *See* Opinion at 5a.

(continued)

repeatedly explains that the basis of medically needy eligibility is net income. For example:

> [T]hose who apply as medically needy must . . .be financially eligible, i.e. any *net income* (after deduction of applicable disregards and incurred medical expenses) and resources of the applicant must be within the medically needy income and resource levels. . . .§4-30-30, p.1 (emphasis added).

See also Massachusetts Public Assistance Policy Manual, Ch. IV, p. 15, ¶ 20 ("*Available net income* . . .is used to determine MA eligibility").

The Secretary's reliance on cases upholding "imprecise" or "prophylactic" classifications in Social Security Act programs is thus perversely inappropriate. *E.g., Califano* v. *Jobst, supra; Weinberger* v. *Salfi,* 422 U.S. 749 (1975). In these cases, the Court upheld classifications challenged on the ground that they failed to "filter . . .out those, and only those, who are in the factual position which generated the congressional concern reflected in the statute." The Court found that Congress's intent to avoid the "expense and other difficulties of individual determinations justified the inherent imprecision of prophylactic rules." *Id.* at 777. These cases are authority for the proposition that, even though the appellees are identically situated to SSI recipients when medical expenses are considered, a state is not constitutionally obligated to consider expenses; it can deter-

---

(footnote continued from preceding page)

More fundamentally, the statute leaves no room for argument as to whether the two sets of standards are comparable: it explicitly *mandates* that they be "comparable" in section 1902 (a) (17). The Secretary previously has consistently indicated understanding that the two sets of standards are comparable by requiring, pursuant to section 1902 (a) (17) that a state's medically needy standards be no lower than its SSI standards, except where the SSI standards exceed the four-thirds maximum. 45 C.F.R. 435.812–14.

mine eligibility on the less precise but simpler basis of gross income.

Here, in contrast to these cases, Massachusets has specifically chosen *not* to adopt an imprecise rule which would determine eligibility only on the basis of gross income. Rather it has decided to make "individualized determinations" of the impact of medical expenses on financial need. The discrimination against the appellees does not avoid administrative expenses or difficulties; Massachusetts does operate an eligibility process that measures income and medical expenses. This process *does* "filter . . .out those, and only those, who are in the factual position which generated the congressional concern reflected in the statute." The appellees' claims arise from the fact that, having filtered them out, it then arbitrarily discriminates against some of them by providing less benefits.

B. There is no rational basis for the classification.

The basis of the District Court's decision is simple. "[A] general rule may not define the benefitted class by reference to a distinction which irrationally differentiates between identically situated persons." *Califano* v. *Jobst, supra* at 53. There is no dispute that the appellees are identically situated to SSI recipients in terms of the categorical criteria of age and disability. Thus, *Jefferson* v. *Hackney,* 406 U.S. 535 (1972), which permits different eligibility standards for different categorical groups, is irrelevant here, and contrary to the Secretary's suggestion (Brief at 21), the decision below casts no doubt on the validity of the 1981 Medicaid amendments authorizing states to apply different standards to different categorical groups within the categorically and medically needy classes.[26] And of

[26]Indeed, Massachusetts has always applied different standards to aged and disabled SSI recipients. *See* Appendix A. The appellees have never challenged the distinction between the aged and disabled, but only the distinction between the treatment of each SSI group and the corresponding medically needy group.

course there can be no claims here that the disadvantageous treatment of the appellees functions as a work incentive, *compare Dandridge* v. *Williams*, 397 U.S. 471, 486 (1970), or that it reflects any judgment of the relative equities of the claims of the two groups. *Compare Id.; U.S. Railroad Retirement Board* v. *Fritz, supra* at 460. The Act presumes that people in the situation of the appellees are no longer in the labor market, and the classification reverses the only conceivable equitable distinction between the two groups. And as we have shown in the preceding section, the appellees and SSI recipients are identically situated in terms of the relevant criteria of need. *See Bacon* v. *Toia*, 648 F. 2d 801, 806-09 (2d Cir.), prob. jur. noted sub nom. *Blum* v. *Bacon*, 50 L.W. 3486 (Dec. 14, 1981) (New York Emergency Assistance provision providing benefits to non-AFDC families but denying them to AFDC families meeting the same categorical and need criteria invalid under minimum rationality test).

Only two bases were suggested below for the distinction between appellees and SSI recipients: encouraging the purchase of private insurance and encouraging the purchase of Medicare. Although we do not understand the Secretary to press them here, we will discuss them briefly to show that the District Court correctly rejected them.

Private insurance. Congress did express concern in 1967 that high medically needy standards might discourage people able to purchase private insurance from doing so, but these concerns were irrelevant to people in the situation of the appellees in two respects. First, the references to private insurance were to "individuals in or close to an average income range," H. Rep. No. 544 at 118, or to the New York program which set eligibility standards close to the median income. 113 Cong. Rec. 23091 (Rep. Stratton). Second, these concerns did not apply to the aged and disabled at all, but to the "adult working population."

H. Rep. No. 544, *supra* at 118 (emphasis added); *see also* 113 Cong. Rec. 23091 (Rep. Stratton: "employees" discouraged from purchasing coverage). Congress's concern was simply that standards such as New York's would discourage middle class families from purchasing insurance. *See* R. Myers, *Medicare* 290-91 (1971). As we showed in section I (A) (2), Congress never considered that the four-thirds maximum would require the medically needy to spend down below the categorically needy standards, and thus obviously it never determined that applicants with more gross but less net income than SSI recipients were better able to purchase private insurance.

Indeed, the suggestion that the medically needy and SSI recipients are differently situated from any point of view contradicts the basic legislative principles that in medically needy programs need be determined on the basis of net income and in terms of comparable standards. Since the private insurance argument is not "consistent with the history and context" of the statute, it cannot provide a basis for a finding of minimum rationality. *Weinberger* v. *Wiesenfeld*, 430 U.S. 636, 655 (1975) (Rehnquist, J., concurring). Nevertheless, even if one were willing, contrary to Congress's approach to the matter, to speculate on whether less favorable treatment to the medically needy might be hypothetically justified as an incentive to purchase private insurance, one would have to conclude that it could not.

If the argument is that the appellees' higher gross income gives them a greater present ability to purchase insurance than SSI recipients, then, aside from the fact that there is no data to support it, the argument simply ignores that the cost of insurance depends in substantial part on the health and medical needs of the purchaser. *See, e.g.*, H. Denenberg, *et al.*, *Risk and Insurance* 509, ch. 21 (3d ed., 1974). The advantage gross income gives the appellees is offset by their medical needs. One can receive SSI without having any medical expenses; by con-

trast each appellee has medical expenses of at least the amount of the difference between gross income and the SSI standards.

If the argument is that setting the medically needy standards below the SSI standards gives people currently working an incentive to purchase insurance which will provide coverage after retirement or disability, then, aside from the fact that there is no data to support it, the argument is untenable for at least these reasons: First, it assumes a degree of knowledge about Medicaid eligibility among current workers which is unlikely and a propensity to believe that current practices will continue which would be foolish. Indeed, the argument assumes, not only that the expectation of the future application of current Medicaid policies has an incentive effect, but that the expectation of having to spend down below the cash assistance standards would have a substantially greater incentive effect than the expectation of simply having to spend down to the cash assistance standards. This is wildly implausible.

Second and more fundamentally, even if one does assume that current workers know about and rely on current Medicaid practices in planning for retirement or disability, it is more likely that the discrimination will encourage them to behave in ways other than purchasing insurance which will increase Medicaid costs. The incentive created by the discrimination for people who fear ending up in the situation of the appellees is to act so as to reduce post-retirement income (by working or saving less or investing their money in their homes) so as to enable them to qualify for SSI and categorically needy coverage.

Moreover, both versions of the argument ignore that there is no private insurance available which covers the services for which a majority of Medicaid expenditures are made on behalf of the aged. Intermediate and skilled nursing home care alone account for more than 70 percent of Medicaid expenditures on

behalf of the aged. *Data on the Medicaid Program, supra* at 67. Yet virtually all such care is excluded in the private coverage available for the aged.[27] J. Feder and J. Holahan, *Financing Health Care for the Elderly* 71, 103, n. 12 (Urban Institute, 1979). While Congress had no information before it concerning the insurance available to the aged in 1967, it considered extensive evidence in connection with the original enactment of Medicaid showing that worthwhile private insurance is generally not available to the aged. *Blue Cross and Other Private Health Insurance for the Elderly: Hearings Before the Subcommittee on the Health of the Elderly,* 89th Cong., 2d Sess. 2-13, 47-54 (1964); *Medical Care for the Aged: Hearings Before the Committee on Ways and Means,* 89th Cong., 1st Sess. 40-44 (1965). Congress deemed even the available hospital coverage, which according to these data was the coverage by far most accessible, to be so inadequate as to warrant establishment of the general hospital insurance program of Medicare, Part A.[28] 42 U.S.C. 1395c *et seq.*

Indeed, even if the discrimination against the appellees were rationally related to the purpose of encouraging the purchase of private insurance, there would be no reason to presume that

---

[27] A minor exception is private coverage of the deductible for Medicare nursing home coverage, which is itself extremely limited. *See* J. Feder and J. Holahan, *supra* at 9–10, 103, n. 12.

[28] Private insurance has played only a minor role in financing health care for the aged since the enactment of Medicare. In 1967, insurance paid 5.9 percent of medical expenditures for the elderly. Gornick, *Ten Years of Medicare,* Social Security Bulletin 3, 18 (July 1976) (as opposed to 33.5 percent of 1967 expenditures for the population as a whole, Mueller, *Private Health Insurance in 1973,* Social Security Bulletin 21, 37 (February 1975). In 1976, it paid 5.4 percent of expenditures for the elderly (as opposed to 26 percent for the population as a whole). Gibson, *et al., Age Differences in Health Care Spending,* Social Security Bulletin 3, 9 (August 1977).

encouraging the purchase of private insurance would be a rational way to reduce Medicaid expenditures. From the point of view of Medicaid eligibility, the purchase of private insurance by an applicant merely substitutes one medical expense for another. The applicant can still establish eligibility for Medicaid coverage of expenses not covered by the insurance, and in determining eligibility Medicaid must credit the premium cost, like any other medical expense, against surplus income. 42 U.S.C. 1396 a(a) (17) (D); 42 C.F.R. 435.831. In effect, Medicaid pays the cost of insurance for the medically needy since the premiums decrease the amount the applicant must spend down (and increase the amount the state must pay) for other medical expenses. Thus, Medicaid could save money by encouraging the purchase of private insurance only if the benefits provided by the insurance for services for which Medicaid would otherwise have to pay exceeded the premium expense. Yet, it appears that the opposite is the case with respect to the insurance available to the aged and disabled,[29] and indeed that

[29]There are at least three reasons why purchase of private insurance by the aged and disabled would increase rather than reduce Medicaid expenditures. First, to the extent that insurance does not cover expenses which Medicaid does cover, Medicaid saves nothing, even though it subsidizes the premium expense. As we note above, private insurance does not cover the services for which the majority of Medicaid expenditures on behalf of the aged are made. *Data on the Medicaid Program*, *supra* at 67; J. Feder and J. Holahan, *supra* at 71. Second, private insurance may cover expenses Medicaid covers but do so at greater cost. A substantial portion of private insurance premiums goes for administrative, advertising and sales expense and for profit. It appears that this portion is unusually high with respect to the insurance sold the aged, often exceeding 50 and in some cases 80 percent. J. Felder and J. Holahan, *supra* at 83–88. Third, if as the Secretary suggests at page 19, n. 21 of his brief, the private insurance covers services Medicaid does not cover, then Medicaid saves nothing but, by crediting the premiums, subsidizes services for which it would not have to pay if insurance had not been purchased.

Congress itself has so concluded, at least with respect to the aged.

Since the insurance argument is unsupported by legislative judgment, judicially noticeable data, or *a priori*, common sense plausibility, the lower court correctly rejected it.

Medicare. The Secretary suggested unsuccessfully below that the lower medically needy standards might be rationally related to the purpose of encouraging the medically needy to accept Part B Medicare coverage.[30] A general reduction of benefits to all medically needy applicants regardless of whether they have Part B coverage would have been an absurdly crude means of dealing with Part B disincentives. Congress has done nothing so irrational. In 1967 Congress did express concern that Medicaid might discourage the purchase of Part B coverage. H. Rep. No. 544, *supra* at 118. However, it dealt with that concern, not through the limitation on income standards, but through the "buy-in" provisions facilitating state purchase of Medicare for Medicaid applicants who do not have it.[31] *Id.* at 119-20; 42 U.S.C. 1395v, 1396b (b) (1), as amended Pub. L. 96-499, §945(e) (1980). The "buy-in" provisions complete the integration of Medicaid and Medicare in a manner which leaves no role for the income limitation.

---

[30] Although the Secretary refers to Part B as "optional" coverage, as did some legislators in 1967, since the 1972 amendments providing for automatic enrollment, Part B has been "optional" only in the sense that a recipient may "opt out" by affirmatively declining coverage. 42 U.S.C. 1395p(f); 42 C.F.R. 405.210. (Having done so, however, he or she can re-enroll at any time. Pub. L. 96-499, § 945(a) (1980).)

[31] The House Report makes no mention of the Medicare disincentive issue under the heading "Limitations on Eligibility," *supra* at 118–19, and the Senate Report makes no mention of it under the heading "Limitations of federal financing participation under Title XIX," *supra* at 176–77.

In determining Medicaid eligibility, the state, as with private insurance, credits the Medicare Part B. premium cost against surplus income, 42 C.F.R. 435.831(c), and Medicaid pays only costs not covered by Medicare. Since the applicant gets credit for the premium cost, there is no real disincentive to take Part B coverage. Nevertheless, to the extent that the problem does arise, the "buy-in" provisions provide a complete remedy: the state Medicaid program simply purchases Part B coverage for the recipient. The financial effect to the state of buying in is the same as when the applicant pays the premiums; instead of crediting the applicant's premium payment against surplus income and thus increasing the amount Medicaid pays for other services, the state itself pays the Medicaid premium and increases the amount the individual pays for other services.[32] *See Lindsey* v. *Normet,* 405 U.S. 56, 71 (1972) (double bond requirement for tenant appeals cannot be sustained as related to protection of landlord's interests where danger to those interests remedied by other statutory provisions).

Moreover, even if there were a problem with respect to Part B coverage, it could not provide a basis for a distinction between the medically and categorically needy aged because the two groups are not differently situated with respect to such coverage. Aged SSI recipients, whether or not eligible for Social Security, are also eligible for Medicare, 42 U.S.C. 1395i-2, 1395o, and it cannot be maintained that any disincentives for them would be different than they are for the appellees.[33]

[32]Even without the "buy-in" provisions, Congress could solve any problems with respect to Part B coverage simply by authorizing the state to require applicants to purchase it as a condition of eligibility.

[33]There is now a difference in the situation of disabled members of the appellee class and disabled SSI recipients with respect to Part B because SSI recipients not also eligible for Social Security are not eligible for Medicare. However, in 1967 the situation of the two disabled groups was identical: neither was eligible for Medicare.

CONCLUSION

The decision of the District Court should be affirmed.

Respectfully submitted,

WILLIAM H. SIMON
GARY BELLOW
MARK COVEN
GILL DEFORD
Counsel for Appellees

January 1982

Appendix

APPENDIX A

CURRENT INCOME STANDARDS

The currently effective Massachusetts SSI income standards, 106 C.M.R. 327.030, and Medicaid medically needy income standards, 106 C.M.R. 506.400, follow.

506.400: MA Income Standards

The MA Income Standards are the standards of need established by the Department and used for the determination of financial eligibility.

Eligibility shall be established for an otherwise eligible individual whose Net MA Income is equal to or less than the applicable MA Income Standard. If Net MA Income is greater than the MA Income Standard, eligibility may be established on the basis of the spend-down provisions.

506.410: Community Cases

The following table provides the MA Income Standards applicable to AFDC-Related and SSI-Related filing units residing in the community.

TABLE OF MA INCOME STANDARDS
COMMUNITY CASES

Number of Persons	Income Standard
1	$333
2	425
3	435
4	445
5	510
6	576
7	641
8	706
9	771
10	836
Each additional person	+ 66

CHART OF COMBINED SSI AND STATE SUPPLEMENT PAYMENT STANDARDS EFFECTIVE JULY 1, 1981 (Revised)

LIVING ARRANGEMENT

Category	A Full Cost of Living Expenses	B Shared Living Expenses	C Household of Another	D Domiciliary Care (Licensed R.H.)
Individual				
Aged	$401.92	$312.36	$286.43	$444.68
Disabled	387.49	303.50	269.65	444.68
Blind	422.84	422.84	422.84	422.84
Member of a Couple				
Aged	305.66	305.66	244.44	444.68
Disabled	294.83	294.83	233.63	444.68
Blind	422.84	422.84	422.84	422.84

NOTES:

1. Living Arrangement D (Boarding) was discontinued on October 1, 1976; individuals in that living arrangement were reclassified to Living Arrangement B.
2. These figures represent an 11.2% cost-of-living increase in the federal portion and increases in the combined federal and state benefits ranging from 5.8% to 10.4%, except for rest home standards, which will increase 27%.
3. The personal care allowance in licensed rest homes remains constant at $79.84.
4. The minimum income level of each mandatory minimum supplement case is increased by the total federal increase since December, 1976 for the living arrangement applicable to the particular individual. In addition, as of October 1, 1981, the $10 cash-out value for food stamps will be deducted for these cases.

APPENDIX B

STATUTORY PROVISION INVOLVED

Section 1902(a) (17) of the Social Security Act, 42 U.S.C. 1396a (a) (17) is as follows:

> A State plan for medical assistance must . . . (17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program estab-

lished under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law.

APPENDIX C

MEDICAL ASSISTANCE MANUAL

Excerpts from Department of Health, Education and Welfare, Medical Assistance Manual, follow. The manual is a set of program explanations and instructions to State Medicaid programs. *See Smith* v. *Trainer,* (N.D. Ill. 1979), CCH Medicare and Medicaid Guide, ¶30, 435 at 9691, 9694n.7

4-30-30 Medically Needy [p. 4]

B. *Financial Eligibility* 45 CFR 248.3(c))

Within Federal requirements explained below, each State with a medically needy program defines income and resource levels which are adjusted by family size and which apply to *all* persons who establish eligibility as medically needy. In determining financial eligibility, gross income is reduced by disregards appropriate to the applicant's eligibility category (i.e., families and children or aged, blind or disabled individuals). Eligible applicants who meet the resource limits qualify for Medicaid coverage when they have [p. 5] incurred medical expenses equal to the amount of net income they have above the appropriate (family size) income level.

(1) *Income*

a. *Setting Medically Needy Income Levels (MNIL)* (45 CFR 248.3 (c) (1) (i-iii) and 248.4(b) (4))

Medically needy income levels are established in total dollar amounts, sufficient to meet basic maintenance needs of the individual or family.

. . .

[p. 10]

(5) *Cost-of-Living Variations (Sec. 1902(a) (17) of the Act)*

Although there are obvious advantages to a single income level for each family size, and this method

is preferred, a State agency is not precluded from having separate income levels which reflect justifiable variation in cost of shelter in urban and rural areas.

Such income levels must be expressed in total dollar amounts for all maintenance needs (including shelter costs and appropriate special [p. 11] need items). This method permits States to recognize differences in the major variable consumption item of shelter without unduly complicated administrative procedures to determine eligibility. There may not be a different level for maintenance for persons who own their homes, and for those who rent, nor may shelter costs be added to the income levels on an "as paid" or "as paid to a maximum" basis.

States are encouraged to limit such differentials to two or three, based on cost-of-living differentials recognized in the State AFDC plan, and supported by data sufficient to justify that the differentials actually reflect appreciable variations in living costs within the State.

b. *Determining Available Income*

(1) *General* (45 CFR 248.3(c) (4))

"Available income" means any amounts which are actually "in hand" or under control of the applicant, over a period not to exceed 6 months ahead; i.e., the State shall not assume that income the applicant might receive beyond a 6-month prospective period will in fact be available.

Where financial eligibility is routinely determined on an annual basis, the amount of income to be measured against the annual medically needy income level is based on amounts which the applicant can reasonably be expected to have during the next 6 months.

. . . .

[p. 16]

d. *Application of Excess Income; the "Spend-Down"* (45 CFR 284.3(c) (2)). The amount of net income available to the individual or family after deduction of applicable disregards is "countable income", to be measured against the appropriate family-size MNIL.

Where countable income is equal to or less than the appropriate income level, eligibility as medically needy is established (providing all the other conditions of eligibility are met). Where countable income is greater than the appropriate income level, the difference is "excess income"; financial eligibility as medically needy is not established until the applicant(s) has incurred medical expenses equal to the amount of such excess income (the "spend-down").

. . . .

[p. 19]

When the applicant can show that, during the period for which his income is evaluated in the eligibility determination, he has incurred or will incur medical expenses in an amount sufficient to reduce his income to the applicable medically needy income level, he is entitled to Medicaid coverage (provided he is otherwise eligible) for any additional care or services he needs which are included in the plan.

APPENDIX D

The following are excerpts from the Massachusetts Public Assistance Policy Manual, ch. IV, para. B as in effect at the time of the decision below. (Massachusetts has re-written and repromulgated all its Medicaid regulations, effective January, 1981, but the revisions do not affect the substance of the provisions below.)

[p. 15, ¶20]

Determining Available income in MA

Definitions

. . .

Available Net Income — The amount of income remaining after application of the disregards for special and general income. This amount is used to determine MA eligibility.

[p. 17, ¶f]

F. *Available Net Income in MA (Surplus Income)*

If the net monthly income exceeds the basic exemptions under the MA program, the available excess net income for the calendar month in which medical care or services are provided and for the five subsequent months, must be applied toward payment for said medical care or services. This is a closed end six month period. The next six month period for applying available excess net income will begin with the month in which medical care or services are again incurred following the initial closed end six month period.

In calculating the case's liability for medical services, surplus income is six times the available excess net monthly income.

Eligible Cases:

When a case has surplus income equal to or more than the estimated medical expense for a six month period, the applicant should be notified that his application is denied for this reason. This applicant should also be informed that a new application can be made if medical expenses exceed the available excess net income in the future.

When medical expense is more than the surplus income then the applicant is eligible and MA will be responsible for all approved medical expense which is an excess of the six months' liability, less any other resource such as health insurance coverage.

When the eligible client has incurred expenses for medical care or services which equal or exceed his surplus income, he must submit his itemized bills or receipts to his WSO. The client must be notified of the above procedure and of his eligibility including a statement of his surplus income for this closed end six month period. He must also be notified of his responsibility for payment of medical care or services up to this amount. The submitted bills or receipts are to be recorded according to vendor processing instructions. When it has been determined that the liability has been met an SSOA authorization form must be completed according to processing instructions.

APPENDIX E

REGIONAL OFFICE MANUAL

The following are excerpts from Department of Health, Education and Welfare, Health Care Financing Administration, Regional Office Manual, Pt. 6, Medicaid Guidelines, Transmittal No. 31 (June 19, 1979). The complete text appears at CCH *Medicare and Medicaid Guide* ¶30,392.

[§2572 — Medically Needy: Determination of a Medically Needy Income Level for Two Adults]

This is in response to a request for clarification of policy regarding the establishment of medically needy income levels. Specifically, the request addressed the issue of setting a medically needy income level for two adults based upon the AFDC payment to a two-person family composed of one adult and one child.

* * *

This issue involves concerns similar to those inherent in the determination of a medically needy income level for a family of one. PIQ 76-15 (MSA) dated January 22, 1976, addresses this subject and recognizes the existence of the differing maintenance needs of dependent children and medically needy adults.
It reads:

"Per Section 1903(f) (3) of the Social Security Act and 42 CFR 435.1007 in applying the 133 1/3 percent limitation to the medically needy income levels for single individuals, the "highest amount which could ordinarily be paid" under the state AFDC program is an amount reasonably related to the state AFDC payment for two-person families. Where there is no amount of payment for two-person

families, for example, because the AFDC plan does not provide for payments to single individuals, or such payments are based on reduced need standards applicable only to dependent children and are therefore not related to reasonable maintenance needs of medically needy adults, an amount for one-person families must be established by the state to meet the requirements of this provision."

. . . .

In order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child, the states may set a separate medically needy income level for two adults which would be established between 133 1/3 percent of the AFDC payment level for one person and 133 1/3 percent of the AFDC payment level for a family of three persons. For example, Montana has established a medically needy income level for two adults at $287 which is within the aforementioned limits of $167 and $334 respectively. This level conforms to the above criteria, satisfies the regulatory requirement of "reasonable relatedness," and recognizes the differing maintenance needs of an adult and a child. The medically needy income level for one adult and one child may not, of course, exceed 133 1/3 percent of the AFDC cash payment for a family of two persons.

In view of the greater maintenance needs of an adult as opposed to a child, the regulatory mandate of "reasonably related" income levels contain in 42 CFR 435.1007, and in the interest of comparable treatment of persons with similar needs, the states should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person [sic] composed of two adults.

APPENDIX F

MASSACHUSETTS' COST ESTIMATE

Massachusetts' brief contains an assertion as to the probable fiscal impact of the District Court's decision at pp. 48-49 n. 4. The assertion should be disregarded, first, because it is irrelevant, e.g. *Memorial Hospital* v. *Maricopa County,* 415 U.S. 250, 263 (1974); and second, because it is without support of record, *e.g., Russell* v. *Southard,* 53 U.S. 139,151 (1852). Nevertheless, we feel compelled to note that, aside from these factors, it is patently erroneous. The state has calculated the cost by multiplying its unsupported and unexplained estimates of the number of aged and disabled people who will benefit from the decision by "the average per person Medicaid expenditure[s]" per year for the aged ($2,700) and the disabled ($3,291). This is a gross error; not a single person will benefit as a result of the decision by the *average* annual expenditure.

There is no dispute that, if the decision below is upheld, the appropriate remedy will be to require that the medically needy standards be raised to the SSI standards. The *maximum* amount which this remedy will benefit any member of the plaintiff class is the difference between the applicable SSI and medically needy standards. The greatest differential — that between the standards applicable to aged couples — is $186.32 or $2,235.84 per year. The differentials in the standards applicable to class members who live alone and apply as individuals (rather than as couples) are much smaller, ranging from $12.49 to $26.92 per month as $149.88 to $323.04 per year. See Appendix A. Moreover, only those members of the class who are now spending down to qualify for benefits will benefit by the full differential. Others who cannot now qualify will benefit because they can qualify for some benefits under the higher standards. But they will gain less than those currently spending down because, even after the standards are raised, Medicaid will pay only for their

medical expenses remaining after they have spent down to the SSI standards. These remaining expenses will be less than the full differential between the medically needy and SSI standards; if they were more than the differential these members would have been able to qualify for some benefits under the current standards. Thus, even if the state's estimate of the number of people who will benefit from the decision here is correct, the resulting cost would be a fraction of the state's $10 million per year estimate.

At the risk of dignifying this unsupported assertion, we note that even the state's patently inflated $10 million estimate is about one percent of Massachusetts' current Medicaid budget of $985 million. Similarly, we note that the Secretary's equally unsupported estimate of nationwide fiscal impact at $150 million per year represents about one-half of one percent of the estimated fiscal 1981 nationwide Medicaid expenditures, $29.3 billion. *See* Office of Management and Budget, *budget of the United States Government: Fiscal Year 1982* I-K44 (1981).

Appellee's Brief

2

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981
NO. 81-213

RICHARD S. SCHWEIKER, SECRETARY
OF HEALTH AND HUMAN SERVICES,
APPELLANT,

v.

GEORGE HOGAN, ET AL.,
APPELLEES.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT
OF MASSACHUSETTS

BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS IN SUPPORT OF THE POSITION OF APPELLANT SECRETARY OF HEALTH AND HUMAN SERVICES

FRANCIS X. BELLOTTI
Attorney General
MITCHELL J. SIKORA, JR.
Assistant Attorney General
PAUL W. JOHNSON
Assistant Attorney General

Department of the Attorney
General
2019 McCormack Building
One Ashburton Place
Boston, MA 02108
(617) 727-1032

QUESTION PRESENTED

Whether the Medicaid income eligibility standards created by Section 1903(f) of the Social Security Act (42 U.S.C. §1396b(f)) and by the Massachusetts Medicaid plan conforming to the maximum federal reimbursement thereunder violate equal protection of the law because in operation they permit "categorically needy" applicants to qualify for Medicaid coverage with higher income levels than they permit for "medically needy" applicants.

Table of Contents.

Question presented

Opinion below 2

Jurisdiction 2

Statutory provision involved 4

Statement of the case 4

Prior proceedings 4

Facts 7

A. The assistance programs 8

B. The circumstances of the named plaintiffs 23

Summary of argument 25

Argument 28

Introduction. 28

I. The Occurrence Of Certain Disparate Medicaid Eligibility Standards Between Categorically Needy And Medically Needy Recipients Does Not Deny The Less Favored Group Equal Protection Of The Law. 30

II. Legislative History And Subsequent Legislation *In Pari Materia* Substantiate Congressional Awareness And Tolerance Of The Four-Thirds Formula Of Section 1903(f) Of The Social Security Act. 51

Conclusion 57

Table of Authorities Cited.

Cases.

Allen v. Grand Central Aircraft Co., 347 U.S. 535 (1954)	55n
Andrus v. Shell Oil Co., 100 S.Ct. 1932 (1980)	55n
Bailey v. Clark, 88 U.S. (21 Wall.) 284 (1874)	55n
Califano v. Jobst, 434 U.S. 47 (1977)	32
Chavez v. New Mexico Health and Social Services Department, 84 N.M. 734 (1973)	40
Cheley v. Burson, 324 F.Supp. 678 (N.D. Ga. 1971)	39
Cheley v. Parnham, 404 U.S. 878 (1971)	39

Civil Service Commission v. National Association of Letter Carriers, 413 U.S. 548 (1973) 53

Clark v. Ubersee Finanz-Korporation, A.G., 332 U.S. (1947) 55n

Consumer Product Safety Commission v. GTE Sylvania Inc., 100 S.Ct. 2051 55n

Crammer v. Commonwealth Department of Public Welfare, 449 Pa. 528, 296 A.2d 815 (1972) 41

Curtis v. Child, 95 Idaho 1374 (1972) 41

Dandridge v. Williams, 397 U.S. 471 (1970) 30,32,41,50

Federal Housing Administration v. The Darlington, Inc., 358 U.S. 84 (1958) 54-55n

Freeman v. Parham, 475 F.2d 185 (5th Cir. 1973) 39

Fullington v. Shea, 404 U.S. 963 (1971) 37,41

Fullington v. Shea, 320 F.Supp. 500 (D. Colo. 1970) 37,38

Gould v. Klein, 150 N.J. 40 (1977) 40

Henry v. Betit, 323 F.Supp. 418 (D. Alaska 1971) 39

Jefferson v. Hackney, 406 U.S. 535 (1975) 34,50

Jimenez v. Weinberger, 417 U.S. 628 (1974) 36

Lindsey v. Natural Carbonic Gas Co., 220 U.S. 61 (1911) 31

Maher v. Roe, 432 U.S. 464 (1977) 33

Mathews v. DeCastro, 429 U.S. 181 (1976) 32

Mathews v. Lucas, 427 U.S. 495 (1976) 33-34

Mathews v. Eldridge, 424 U.S. 319 (1976) 46

Quern v. Mandley, 436 U.S. 725 (1978) 49n

Red Lion Broadcasting Co. v. Federal Communication Commission, 395 U.S. 367 (1969) 54n

Regional Rail Reorganization Act Cases, 419 U.S. 102 (1974) 53

Richardson v. Belcher, 404 U.S. 78 (1971) 35

Seatrain Shipbuilding Corp. v. Shell Oil Co., 444 U.S. 572 (1980) 54

Schweiker v. Wilson, 101 S.Ct. 1074 (1981) 32,37,43,54

Sweet v. Department of Public Aid, 66 Ill.2d 195, 361 N.E.2d 1118 (1977) 40

United Low Income Inc. v. Fisher, 470 F.2d 1074 (1st Cir. 1972) 39

United States Department of Agriculture v. Moreno, 413 U.S. 528 (1973) 36

Weinberger v. Salfi, 422 U.S. 749 (1975) 34

Williams v. St. Clair, 610 F.2d 1249 (5th Cir. 1980) 38

Constitutional And Statutory Provisions.

United States Constitution:
Fifth Amendment 41
Fourteenth Amendment 41

42 U.S.C. §402 9
42 U.S.C. §416 9
42 U.S.C. §601 et seq. 20
42 U.S.C. §1381 9
42 U.S.C. §1382 10
42 U.S.C. §1382c 10
42 U.S.C. §1382e 10

42 U.S.C. §1396a 12,13,14,20,54
42 U.S.C. §1396b 1,3,4,11,14,20,28
42 U.S.C. §1396d 10

M.G.L. c. 118A, §1 10,11
M.G.L. c. 118A, §2 11
M.G.L. c. 118E, §1 12,14,21,29
M.G.L. c. 118E, §10 14,16,22,29

Miscellaneous.

P.L. 96-272, §310
94 Stat. 500 55

H.R. 618, 91st.
Cong., 1st Sess. 52n

H.R. 1352, 91st.
Cong., 1st Sess. 52n

H.R. 3272, 91st.
Cong., 1st Sess. 52n

H.R. 8283, 91st.
Cong., 1st Sess. 52n

H.R. Rep. 96-900,
96th Cong., 2d Sess. 56

Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Committee on Finance, 90th Cong., 1st Sess. (1967) 46,52

Code of Federal Regulations

42 C.F.R. 435 18n
45 C.F.R. 435 20
44 Fed. Reg. 10553 11

Code of Massachusetts Regulations

106 C.M.R. 304 19n
106 C.M.R. 338 (M.P.A.P.M.) 15,16,17nn;22
106 C.M.R. 325 15

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981
NO. 81-213

RICHARD S. SCHWEIKER, SECRETARY
OF HEALTH AND HUMAN SERVICES,
APPELLANT,

v.

GEORGE HOGAN, ET AL.,
APPELLEES.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT
OF MASSACHUSETTS

BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS IN SUPPORT OF THE POSITION OF APPELLANT SECRETARY OF HEALTH AND HUMAN SERVICES

OPINION BELOW

The opinion of the district court is reported at 501 F.Supp. 1129. It is fully reproduced as Appendix A of the Secretary's Jurisdictional Statement.

JURISDICTION

The district court entered its opinion and initial order on November 21, 1980 (J.S. App. B, 21a), and filed a clarifying order on December 22, 1980 (J.S. App. C, 22a). On April 9, 1981,

pursuant to F.R. Civ. P. 54(b), it entered a final judgment consolidating its prior orders and expressly invalidating Section 1903(f) of the Social Security Act, 42 U.S.C. §1396b(f), and the conforming Massachusetts Medicaid income eligibility standards (J.S. App. E, 25a). On April 22, 1981, the Secretary filed notice of appeal to this Court (J.S. App. G, 28a). On June 11, 1981, Justice Brennan extended the time for docketing the appeal through July 31, 1981. On October 13, 1981, the Court noted probable jurisdiction (App. 45). The Court derives jurisdiction of the appeal from 28 U.S.C. §1252.

STATUTORY PROVISION INVOLVED

Section 1903(f) of the Social Security Act, 42 U.S.C. §1396b(f) is reprinted in full as Appendix H of the Secretary's Jurisdictional Statement, 30a-32a.

STATEMENT OF THE CASE

Prior Proceedings

On April 29, 1980, pursuant to 42

U.S.C. §§1331, 1343 and to 28 U.S.C. §§2201, 2202, the six named plaintiffs commenced this class action for declaratory and injunctive relief against the operation of the Massachusetts Medicaid income eligibility standards for recipients of cash assistance under the original Social Security program: Old Age, Survivors, and Disability Insurance (OASDI) (App. 1, 9-10, 15-21). The six named plaintiffs were three elderly couples receiving monthly OASDI benefits and at the same time qualifying by reason of substantial monthly medical expenses as "medically needy" recipients of Medicaid coverage (App. 15-21).

Because the facts material to the plaintiffs' legal theories were not disputed, the parties approximately 60 days after service composed a statement

of agreed facts (App. 42-43) and submitted cross motions for partial summary judgment upon the issue whether the variant income eligibility standards for Medicaid coverage for OASDI recipients (the "medically needy") and Supplemental Security Income (SSI) recipients (the "categorically needy") denied the medically needy equal protection of the law (App. 2, 3, 44).

After presentation of written and oral argument, the district court on November 21, 1980, rendered an opinion and order in favor of the plaintiffs (J.S. App. A, 1a-21a; 501 F.Supp. 1129). On December 22, 1980, the court issued an order clarifying its conclusion that "the confluence of federal and state requirements" or the "federal-state program" and "not merely the Massachusetts medicaid statute" functioned unconsti-

tutionally (J.S. App. C, 22a). On March 30, 1981, the court certified the lawsuit as a class action (J.S. App. D, 23a-24a) and on April 9, 1981, entered a final partial summary judgment upon the equal protection claim (J.S. App. E, 25a). The defendant Secretary of Health and Human Services filed a timely notice of appeal in accordance with 28 U.S.C. §1252 (J.S. 26a). Thereafter this Court noted probable jurisdiction (App. 45).

Facts

The material facts are undisputed. They consist of the general features of three federal public assistance programs, of the state Medicaid plan, and of the

specific circumstances of the three couples named as plaintiffs.

A. The Assistance Programs.

The three federal programs involved are OASDI, the original contributory Social Security cash assistance system established in 1935; the Supplemental Security Income allowance for the Aged, Blind, and Disabled (SSI), 42 U.S.C. §1381 et seq.; and the Medicaid program created by Title XIX of the Social Security Act in 1965.

OASDI provides income security for the aged and the disabled and their survivors and dependents. A person's

entitlement to benefits accrues at age 65 (or at age 62 for reduced benefits), 42 U.S.C. §402(a),(q)(1), or upon an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to last for a period of not less than 12 months." 42 U.S.C. §§416(i), 423. Payroll taxes paid by workers and employers fund OASDI benefits. Eligibility requires a prescribed amount of employment covered by the tax.

The SSI public assistance program for the aged and disabled extends financial benefits to persons aged 65 or disabled, 42 U.S.C. §§1381, 1382c (a), (2), and (s). SSI eligibility depends upon age, disability, and financial need; SSI payments do not require a work history or tax payments on the part of the

recipient. In accordance with calibrated income standards for individuals or couples, the federal government extends a guaranteed minimum for the aged, blind and disabled, and furnishes an SSI payment sufficient to bring the recipient's income up to that standard. See 42 U.S.C. §1382e. A state has the option to contribute supplementary payments to SSI recipients. See 42 U.S.C. §§1382(c) and 1396d(j). Massachusetts has chosen to raise the SSI income and payment standard through supplementary payments. M.G.L. c. 118A, §1. The Social Security Administration by a unified payment process administers the benefit. See 20 C.F.R. §§416.200k, et seq. Aged and disabled OASDI recipients have their OASDI benefit (minus a $20.00 exemption)

counted against the SSI income eligibility standard. Aged and disabled OASDI recipients whose countable income falls below the SSI standard are eligible to receive an SSI grant in the amount of the difference between that countable income and the SSI standard. See M.G.L. c. 118A, §§1, 2.

Under the Medicaid system established by Title XIX of the Social Security Act of 1965, the states pursuant to federally approved plans pay the costs of medical treatment for categories of persons of insufficient income. The federal government reimburses the states for a percentage of these medical expenses. See 42 U.S.C. §1396b. At the time of the commencement of this action Massachusetts received reimbursement at the rate of 52 percent. See 44 Fed. Reg. 10553 (February 21, 1979).

Pursuant to M.G.L. c. 118E, §1, Massachusetts participates in the Medicaid program. Pursuant to Title XIX it recognizes two basic classes of eligibility: the "categorically needy" and the "medically needy." The categorically needy include persons eligible for benefits under the two principal federally supported cash assistance programs: SSI and Aid to Families with Dependent Children (AFDC). Title XIX commands participating states to provide Medicaid coverage to recipients of AFDC and SSI, if the state elects to participate in the Medicaid program.[1/] See 42 U.S.C.

1/ The sole exception to this requirement is immaterial to the present case. See 42 U.S.C. §1396a(f), permitting states the option to cover only SSI recipients qualifying under the state income guidelines in effect prior to the establishment of SSI in the state-run predecessor old age and disability assistance programs. Massachusetts has not adopted that option.

§1396a(a)(10)(A). Consequently SSI recipients receive a cash grant for their basic needs plus Medicaid coverage. The medically needy include those meeting the noneconomic criteria of the AFDC and SSI programs (families with dependent children, and the aged and the disabled) who remain ineligible for cash assistance because of higher income but "who have insufficient . . . income and resources to meet the costs of necessary medical and remedial care and services." 42 U.S.C. §1396a(a)(10). The medically needy are individuals whose income is too high to qualify them for categorical cash grants but whose medical expenses leave them with income insufficient for their nonmedical needs. Title XIX permits, but does not require, participating states to extend Medicaid coverage to the medically needy. Massachusetts

extends such coverage so long as it receives appropriate federal financial participation or reimbursement. See 42 U.S.C. §1396a(a)(10)(c); 42 U.S.C. §1396b(f); M.G.L. c. 118E, §§1, 10.[2/]

2/ It may be helpful to set out in fuller detail the Massachusetts system of Medicaid coverage for the medically needy. The governing regulations are set forth in the Massachusetts Public Assistance Policy Manual (M.P.A.P.M.), which has largely been codified in the Code of Massachusetts Regulation (C.M.R.). In addition to the coverage afforded to AFDC and SSI recipients, §1 of M.G.L. c. 118E provides that:

> The benefits of the [Medicaid] program shall also be available to all others who would be eligible for financial assistance under any of the foregoing provisions but for income or resources, provided that

(footnote continued)

Under the governing federal statutes

(footnote continued)

> they meet the requirements of financial eligibility under the program hereinafter set forth . . . .

Those persons who would be eligible for SSI or AFDC except for their income or resources are deemed "categorically related," the term used by Massachusetts to describe the medically needy. 106 C.M.R. 325.030(B) (1978). The Department's regulations prescribe certain standards governing the Medicaid eligibility of persons categorically related to the SSI program. 106 C.M.R. 338.020 (1978). In the determination of their net income, such categorically related persons are entitled to disregards for specified types of income. They are also entitled to a disregard of $20.00 of unearned income as well as disregards for earned income. In addition, they receive a monthly net income exemption for maintenance needs. 106 C.M.R. 338.060 (1978), as amended by Mass. Reg. Issue No. 188 at 2 (December 4, 1979) and Mass. Reg. Issue No. 222 at 4 (August 7, 1980). Since July 1, 1980, the Department has allowed the following monthly net income exemptions.

(footnote continued)

a state is entitled to reimbursement

(footnote continued)

NO. OF PERSONS	EXEMPTION ($)
1	334
2	425
3	435
4	445
5	510
6	576
7	641
8	706
9	771
10	836

Income in excess of the monthly net income standard is reduced by monthly costs incurred for medical insurance premiums and enrollment fees. The remaining income in excess of the monthly exemption constitutes the basis for defining surplus income. 106 C.M.R. 338.070 (1978), as amended by Mass. Register Issue No. 188 at 2 (December 4, 1979). In conformity with M.G.L. c. 118E, §10, surplus income is defined as equal to six times the monthly excess. Section 10 mandates:

> In any case where the monthly income of a recipient or beneficiary

(footnote continued)

for Medicaid payments in behalf of a

(footnote continued)

> is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided.

This provision establishes the requirement that medically needy persons spend their surplus income down to zero in payment for medical services within the scope of the Medicaid program. See also 106 C.M.R. 338.070 (1978), as amended by Mass. Register Issue No. 188 at 2 (December 4, 1979). ("All of the . . . surplus income will be applied to the costs of medical assistance provided for in the Medical Care Plan for eligible individuals.") When persons have spent down their surplus income to zero for a six-month period, they are eligible for Medicaid for any other covered services received within that period. See 106 C.M.R. 338.080 (1978). ("When medical expense is more than the surplus income then the applicant is eligible and MA will be responsible for all approved medical expense which is in excess

(footnote continued)

medically needy recipient only if that

(footnote continued)

of the six months' liability, less any other resource such as health insurance coverage.")

Massachusetts derives its monthly net income exemptions from the standard of assistance for its AFDC program. Although federal regulations require a state to use the higher of the AFDC or SSI standards for purposes of determining the minimum medically needy income levels for individuals and two-person families, 42 C.F.R. §435.812, .814, in Massachusetts this requirement would result in a level greater than that permitted under the four-thirds rule. When the required minimum exceeds the permitted maximum, a state is allowed to use the maximum as the minimum. 42 C.F.R. §435.812, .814. Thus, in Massachusetts four-thirds of the lower AFDC standard determines the medically needy income level. Since July 1, 1980, Massachusetts has employed the following AFDC standard of assistance for families:

FAMILY SIZE	TOTAL STANDARD OF ASSISTANCE
1	$247.50
2	$314.20
3	$379.20

(footnote continued)

individual has through medical costs spent down his surplus income to a qualifying benchmark of four-thirds of the amount paid to a family of the same size under the state AFDC program. See

---

(footnote continued)

4	$444.50
5	$509.70
6	$575.10
7	$640.20
8	$705.50
9	$770.90
10	$836.00

106 C.M.R. 304.400 (1978), as amended by Mass. Register Issue No. 223 at 2-3 (August 14, 1980). In accordance with the federally mandated four-thirds rule, the standard of assistance for a family of two presently translates into the monthly net income exemption for Medicaid purposes in the following manner. The amount of $314.20 times 12 times 1.333 equals $5,014.6320, which is rounded up to the next highest hundred. The resulting figure is $5,100.00, which when divided by 12, equals $425.00 [or $25.00 more than the stipulated $400 figure for the named plaintiffs (App. 42) as a result of benefit increases effective since the commencement of the action].

42 U.S.C. §601 et seq.; 42 U.S.C. §§1396a(a)(10((c); 1396a(a)(17)(D); and especially 1396b(f). See also 45 C.F.R. §435.831. As will be seen, in some instances the four-thirds or medically needy qualifying income level will fall below the income level qualifying the SSI categorically needy.

Against this programmatic backdrop the precise "confluence of federal and state requirements" invalidated by the district court (J.S. 22a) emerges as follows.

First, section 1903(f) of the Social Security Act, 42 U.S.C. §1396b(f), in pertinent part limits federal reimbursement of state Medicaid expenditures for medically needy recipients to state compliance with the four-thirds AFDC eligibility spend down standard.

> Limitation on Federal participation in medical assistance

> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under Part A of subchapter IV of this chapter.

Massachusetts General Laws c. 118E, §1 "establish[es], pursuant to and in conformity with the provisions of Title XIX of the Social Security Act, a program of medical care and assistance

for certain residents of the commonwealth." Section 10(1) of M.G.L. c. 118E, in its definition of exempted income and resources of applicants for Medicaid eligibility, excludes any "[m]onthly income in an amount not exceeding the level of the minimum dollar amount required under Title XIX," or in other words adopts the federal reimbursement standards.

Finally the implementing state regulation 106 CMR 338.080 (1981), or Massachusetts Public Assistance Policy Manual Chapter IV, §B, p. 4, ¶6, provides in pertinent part:

> Other Income
>
> Income such as Old Age, Survivor's, and Disability Insurance benefits, Unemployment Compensation, Service in the Armed Forces, Workmen's Compensation, pensions, annuities, trust funds and voluntary contributions of children shall be considered as income to be deducted from the budgeted needs of the recipient.

B. The Circumstances of the Named Plaintiffs.

Under the foregoing federal-state four-thirds spend down eligibility formula for the medically needy, elderly Massachusetts couples such as the named plaintiffs became eligible for Medicaid coverage when their monthly medical expenses had reduced their available income to $400.00 (App. 42).

The plaintiffs George and Pearl Hogan had a combined monthly income of $646.60 from OASDI social security benefits. As a result of surgical treatment for tuberculosis, Mr. Hogan incurred ongoing monthly expenses in excess of $100.00 (App. 42).

The plaintiffs Henry and Celia Beberman had a combined monthly OASDI income of $668.10. Mrs. Beberman suffered from a variety of debilitating conditions requiring daily assistance from a home health aid and weekly visits by a nurse. Her monthly medical expenses exceeded $1300.00 (App. 42).

The plaintiffs George and Cecilia Hunter had a combined OASDI monthly income of $534.70. Mr. Hunter's conditions required twice-a-month amublance visits to the hospital at an unspecified cost. His monthly medication cost over $50.00 (App. 42).

At the same time, a Massachusetts couple receiving SSI assistance might receive a maximum federal allowance of $312.30 and a maximum state supplement of $201.48 for a total of $513.78. With this income the SSI recipient, as cate-

gorically needy, could qualify for Medicaid coverage also (App. 43).

SUMMARY OF ARGUMENT

The disparate Medicaid eligibility standards generated by Section 1903(f) of the Social Security Act for the medically needy and categorically needy do not deny the less favored group equal protection of the law. In the distribution of public assistance funds the Constitution permits the federal and state governments to make rough accommodations between finite resources and competing needs. Dandridge v. Williams, 397 U.S. 471, 485-487 (1970). Indeed, precedent indicates that the government might

decline Medicaid assistance altogether to the medically needy without violation of the equal protection rights of such a disappointed class. Fullington v. Shea, 404 U.S. 963 (1971), summarily aff'g 320 F.Supp. 500, 506-507 (D. Colo. 1970). In the present instance Congress could reasonably have expected the higherincome medically needy recipients to have provided through private medical insurance for subsequent medical expenses and therefore could reasonably have imposed a more demanding demonstration of monthly need (approximately $114 here)
for their Medicaid eligibility. The contrary judgment of the district court would impose significant financial burdens upon the federal and certain state governments (pp. 29-49).

Legislation approved since the enactment of Section 1903(f) and address-

ing the Medicaid eligibility differential has confirmed congressional knowledge and acceptance of the disparity. By specific provisions in 1976 and 1980 Congress has neutralized the spend down discrepancy so as to preserve Medicaid eligibility for specific classes of recipients. With apparent purposefulness it has not done so for the medically needy at large. The legislative history of Section 1903(f) and this subsequent Congressional treatment disprove the district court's conclusion that the eligibility disparity survives as a "legislacive accident" unappreciated by Congress (pp. 49-55).

ARGUMENT

Introduction.

In this litigation the interests of the defendant Massachusetts Secretary of Human Services and Commissioner of Public Welfare (App. 9) (the Commonwealth) derive entirely from those of the federal Secretary of Health and Human Services and the challenged federal statute, Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)), to which the state defendants conformed their challenged state Medicaid plan for the purpose of

maximum federal financial reimbursement M.G.L. c. 118E, §§1, 10. The congruence of these interests and of the underlying legal arguments renders an independent presentation by the Commonwealth largely superfluous. The parties recognized and avoided such redundancy in the district court. The Commonwealth did not notice an independent appeal. Rather, pursuant to Supreme Court Rule 10.4, it submits the present brief in support of the position of the appellant federal Secretary. At the same time it waives any independent entitlement to oral argument.

I. The Occurrence Of Certain Disparate Medicaid Eligibility Standards Between Categorically Needy And Medically Needy Recipients Does Not Deny The Less Favored Recipients Equal Protection Of The Law.

The first principle of this controversy, as announced by the Court in Dandridge v. Williams, 397 U.S. 471, 485-487 (1970), is that a legislative classification scheme involving welfare funds will withstand an equal protection challenge if it does not discriminate invidiously, rests upon a rational basis, and furthers a legitimate state interest. In policies of social welfare the government does not violate the Equal Protection Clause merely because the clas-

sifications made by its laws are imperfect. If the classification draws upon a reasonable basis, it "does not offend the Constitution simply because it 'is not made with mathematical nicety or because in practice it results in some inequality.'" Id. at 485, quoting Lindsey v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1911). This measure of constitutional leeway rests upon important practical grounds of governmental resources, institutional competence, and separation of powers. As all members of the Court recently concurred, "[L]egislation properly enjoys a presumption of rationality, which is particularly strong for welfare legislation where the apportionment of scarce benefits in accordance with complex criteria requires painful, but unavoidable line drawing." Schweiker v. Wilson, 101 S.Ct. 1074,

1087 (1981) (dissenting opinion of Powell, J., for a four-Justice minority). For the same point, see the opinion of the majority, id. at 1085; and Mathews v. DeCastro, 429 U.S. 181, 185 (1976).

The Court has consistently reaffirmed the rule of Dandridge. See Schweiker v. Wilson, 101 S.Ct. 1074, 1082-1085 (Congress may rationally extend monthly SSI comfort allowances to Medicaid recipients in a state medical hospital or a private mental hospital, and not to similarly needy but non-Medicaid recipients in state mental hospitals for whose care it could impute primary responsibility to the states); Califano v. Jobst, 434 U.S. 47, 52-58 (1977) (Congress could reasonably terminate secondary social security benefits received by a disabled dependent child of a covered wage earner upon the

child's marriage to an individual even though the latter was permanently disabled and not receiving social security benefits); Maher v. Roe, 432 U.S. 464, 469-480 (1977) (a state may reasonably extend Medicaid benefits to medically necessary first trimester abortions and not to nontherapeutic first trimester abortions); Mathews v. DeCastro, 429 U.S. 181, 185-189 (1976) (Congress could furnish monthly social security benefits to a married woman under 62 caring for a minor or otherwise dependent child upon the retirement or disability of her husband but not to a similarly situated divorced woman upon the rational premise that the cohabiting married woman then encountered additional family needs while the divorced and presumptively separated woman did not); Mathews v.

Lucas, 427 U.S. 495, 507-516 (1976) (for eligibility for surviving children's social security benefits Congress may put illegitimate children to greater proof of dependency than legitimate offspring because of the latter's more readily documented and demonstrable qualification); Weinberger v. Salfi, 422 U.S. 749, 768-770, 773-780 (1975) (Social Security Act may reasonably impose a nine-month marriage duration requirement upon widows and stepchildren applying for insurance benefits resulting from the death of a covered husband-stepfather so as to reduce the possibility of sham marriages and to eliminate the difficulty and expense of individual inquiries into marriage claims); Jefferson v. Hackney, 406 U.S. 535, 549-551 (1972) (Texas' decision to extend somewhat lower welfare benefits to AFDC recipients than to other

categorically needy aged and infirm recipients may rest upon the rational hypothesis that the young are more capable of self help than the sick and the elderly); and Richardson v. Belcher, 404 U.S. 78, 81-84 (1971) (the Social Security Act's reduction in benefits as a result of a recipient's enjoyment of state workman's compensation payments could rationally seek to eliminate duplicative governmental expenditures and to preserve the rehabilitation or return-to-work purposes of state programs).

By contrast, those decisions invalidating public assistance classifications underscore the lack of a genuine state purpose or of means reasonably furthering

such a purpose. See Jimenez v. Weinberger, 417 U.S. 628, 634-637 (1974) (in order to prevent spurious claims for insurance benefits by illegitimate children of a covered disabled parent, the Social Security Act may not absolutely bar benefits to nonlegitimated afterborn (after the occurrence of parental disability) children and yet permit benefits for previously born nonlegitimated children since that classification failed to reflect the true determinant of actual dependence upon the disabled parent); and United States Department of Agriculture v. Moreno, 413 U.S. 528, 533-538 (1973) (Congress by a provision of the Food Stamp Act may not exclude from the program any household containing an individual unrelated to any other household member because that limitation did not effectively combat

fraud and abuse and because it operated to frustrate the deeper statutory purpose of improved nutrition among low-income households). See also the dissenters' view in Schweiker v. Wilson, 101 S.Ct. 1074, 1085-1089, (emphasizing the arguably identical situation of the disqualified indigent and mentally disabled SSI applicants in state mental hospitals, on the one hand, and those eligible in private mental hospitals and public medical hospitals, on the other; and the arguable absence of a clear congressional policy to be served by the distinction).

As to differential treatment between the categorically needy and the medically needy of the kind at issue here, the Court in Fullington v. Shea, 404 U.S. 963 (1971), summarily affirmed the judgment of a three-judge district court

that under Title XIX a state may opt to exclude altogether the latter class from Medicaid benefits; and that it may impose such an extreme classification for the legitimate purposes of conserving public revenues, reducing excessive or unnecessary medical expenditures, and obviating administrative burdens. Fullington v. Shea, 320 F.Supp. 500, 506-507 (D.Colo. 1970). Since that affirmance, lower federal and state courts have applied and extended the Fullington rationale to analogous circumstances. Cf. Williams v. St. Clair, 610 F.2d 1249-1250 (5th Cir. 1980) (as part of its spend down requirement for medically needy Medicaid applicants, Mississippi could constitutionally allow institutionalized persons to anticipate medical expenses and refuse

to do so for noninstitutionalized persons); Freeman v. Parham, 475 F.2d 185 (5th Cir. 1973) (the Social Security Act did not require Georgia to institute a Medicaid program for the medically needy); United Low Income Inc. v. Fisher, 470 F.2d 1074, 1077 (1st Cir. 1972), aff'g 340 F.Supp. 150, 154 (D. Maine, 1972), (Maine could constitutionally terminate a component AFDC program of benefits to children of unemployed fathers and concomitant Medicaid coverage in order to encourage the Congressional objective of self-supporting employment and in order to reduce state welfare expenditures); Cheley v. Burson, 324 F.Supp. 678 (N.D. Ga. 1971), appeal dismissed sub nom. Cheley v. Parnham, 404 U.S. 878 (1971) and Henry v. Betit, 323 F.Supp. 418 (D. Alaska 1971) (a fortiori Georgia and Alaska could refuse to embark

upon such a component AFDC-Medicaid program); Sweet v. Department of Public Aid, 66 Ill. 2d 195, 361 N.E.2d 1118 (1977) (state program could validly withhold Medicaid eligibility under an AFDC definition of dependence favoring the unemployed over the working poor); Gould v. Klein, 150 N.J. Super. 519, 376 A.2d 196 (1977) (Title XIX did not require state to furnish Medicaid to the medically needy or to deduct an applicant's medical expenses from income computed for Medicaid eligibility). Contrary decisions rejecting more rigorous Medicaid income eligibility standards for the medically needy have done so upon the specific terms of state legislation, and not upon the basis of federal equal protection or statutory requirements. See Chavez v. New Mexico Health and Social Services Department, 84 N.M. 734, 507

P.2d 795 (1973); Curtis v. Child, 95 Idaho 63, 501 P.2d 1374 (1972); and Crammer v. Commonwealth Department of Public Welfare, 449 Pa. 528, 296 A.2d 815 (1972).

In this state of the law, the four-thirds formula of Section 1903(f) of the Social Security Act and the Massachusetts' conforming state Medicaid plan eligibility for the medically needy do not violate the equal protection standards of the Fifth and Fourteenth Amendments. The doctrine of Dandridge and the holding of Fullington and comparable lower court decisions buttress that conclusion. So too do several factual characteristics of the present action. As the premise for an equal protection claim, the similar situation of the categorically needy and the medically needy is not established. By definition

the medically needy, prior to the onset of their expenses, enjoyed a higher income level than the categorically needy, and might be expected to do so again after the passage of their expenditures. The greater ability of that class to anticipate and to absorb medical expenses through alternate insurance coverage or savings separates them from their SSI counterparts. Congress could have, and apparently did, appreciate these variant capacities by statutory definition. By compressing the time frame of comparison to the moment of application for Medicaid by the medically needy and categorically needy, the plaintiffs have removed from the picture the broader and distinguishing circumstances of self-help capability which the Congress was entitled to attribute to the medically needy. By

contrast, the similarity of the cicumstances of the classes of indigent and medically ill applicants in Schweiker v. Wilson was far more static than the circumstances compared here; but nonetheless insufficient to overcome budgetary considerations. 101 S.Ct. at 1084-1085. The same result in this instance would seem to follow a fortiori.[3/]

Further, the plaintiffs and the members of their class are not necessarily medically needy individuals deprived of Medicaid coverage but rather may be Medicaid recipients merely satisfying a more arduous eligibility standard. Four

---

3/ The Secretary correctly draws attention to that important distinction between the classes. Jurisdictional Statement at 25-26; Reply Brief at 6-7.

of the six named plaintiffs qualify for coverage (the Bebermans, App. 42; the Hunters, App. 38); and the remaining couple would appear to have medical expenses qualifying them for coverage (the Hogans, App. 42, paragraph 2, reciting figures ostensibly satisfying the $400 spend down standard; but compare their affidavit allegation of actual or imminent disqualification, App. 33-34). Beyond that circumstance the Record does not inform us of what number of medically needy applicants suffer exclusion from Medicaid as a result of the differential income standard. The pre-judgment stipulation did not touch the subject (App. 42-43); and the district court's indiscriminate post-judgment class certification prevented further development of that information (J.S. 23a-24a). As to

those medically needy individuals receiving benefits, the maximum disparate qualification is the expenditure of an additional $113.78 per month (App. 42-43). That figure embodies the greatest possible differential because it compares the medically needy eligibility level of $400.00 per month with the maximum allowance of $513.78 received by SSI recipients (id.). Again, the record highlights the extreme differential and does not reflect the more typical or intermediate SSI grants narrowing the monthly income differential, and therefore the alleged discrimination, between the two classes. Just as equal protection doctrine in the setting of public assistance does not compel mathematical equality and permits rough-hewn adjustments between governmental resources and

objectives, so too it should embody reliably general, rather than exceptional or dramatic, circumstances. Cf. Mathews v. Eldridge, 424 U.S. 319, 344 (1976).

Finally the preservation of funds, federal and state, supports the eligibility differential. Economy obviously motivated Congress in 1967 to prefer a four-thirds rather than a three-halves eligibility rule. See Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. (1967) 280-282 (testimony of HEW Undersecretary Wilbur Cohen in support of the Administration's three-halves amendment). See also the legislative history collected and discussed in the Secretary's Jurisdictional Statement at 13-21. That selection

overrode objections about possible inequity to the medically needy. Jurisdictional Statement at 13-21. And, as already discussed, Congress could reasonably have expected greater self-sufficiency from a class enjoying a higher level of income. Considerations of economy remain important in the wake of the district court judgment. For the remedy necessarily generated by the judgment below is the elimination of the eligibility gap between the medically and categorically needy by the federal or state governments, or both. If the federal or state treasuries must equalize the income eligibility figures by abolition of the medically needy spend down differential, their expenditures

could prove substantial.[4/] Alternatively the federal or state governments could reduce SSI benefits to a line of parity with medically needy eligibility for Medicaid. That adjustment might furnish a constitutional solution at the sacrifice of considered policy objectives

---

4/ The Secretary estimates that the district court's judgment, if affirmed, could affect 15 other states and could result in an increase of federal and state Medicaid expenditures of more than $150 million in fiscal year 1983. J.S. 10.

The Commonwealth estimates a potential 10 million dollar increase in Massachusetts for that year. Projections based upon the caseload experience of recent years indicate that the district court's new Medicaid eligibility standard would add 2,772 elderly cases and 828 disabled to the program; that the average per person Medicaid expenditure for a community resident (i.e. a recipient not confined to a chronic care facility) would be $2,700.00 per year for the elderly and $3,291.00 for the disabled. The resulting sum of the elderly (2,772 x $2,700 = $7,484,400) and disabled (828

(footnote continued)

in behalf of the categorically needy. The complexity and painfulness of such

---

(footnote continued)

x $3,291 = $2,724,948) would total $10,209,348 in combined federal and state expenditure.

Beyond its fiscal impact, the district court's judgment would erode the principle of cooperative federalism underlying the medically needy program. Congress has carefully structured that program to maintain the fiscal autonomy of participating states. Compare Quern v. Mandley, 436 U.S. 725, 746 (1978) (Emergency Assistance program was structured to allow for "meaningful fiscal [and] programmatic control by the States"). By their power to define the income eligibility standard within certain federal limits, states can control the cost of extending Medicaid to their medically needy population. By contrast, the district court's judgment would tie that standard to the SSI standard of need, which is established for the most part by the federal government. Supra, pp. 9-11. In order to extend Medicaid to their medically needy population, states would thus be required to assume whatever costs might flow from the federally established SSI standard. The imposition of such an open-ended liability frustrates the permissible legislative goal of preserving the fiscal autonomy of the participating states.

remedial choices highlights their essentially legislative character. Indeed the prospect of a remedy to implement the district court's summary rejection of a conscious Congressional policy bodes disruption for existing federal and state financial allocations and further judicial supervision over state appropriations decisions. Such a remedial effort would vindicate once again the Court's dominant approach to equal protection challenges to public assistance policies as expressed in Dandridge v. Williams, 397 U.S. 471, 487 (1970), and reemphasized in Jefferson v. Hackney, 406 U.S. 535, 551 (1972):

> We do not decide today that the [state law] is wise, that it best fulfills the relevant social and economic objectives that [the State] might ideally espouse, or that a more just and humane system could not be devised. Conflicting claims of morality and intelligence are raised by opponents and proponents of almost every measure, certainly including

> the one before us. But the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of this Court. . . . [T]he Constitution does not empower this Court to second-guess state officials charged with the difficult responsibility of allocating limited public welfare funds among the myriad of potential recipients.

II. Legislative History And Subsequent Legislation In *Pari Materia* Substantiate Congressional Awareness And Tolerance Of The Four-Thirds Formula Of Section 1903(f) Of The Social Security Act.

The Commonwealth subscribes to the thorough analysis of legislative history underlying the enactment of Section 1903(f) in 1967, as presented by the Secretary in the Jurisdictional Statement at 2-21 and stressed in his Reply Brief at 1-5. That discussion clearly evinces

Congressional appreciation of the possibly uneven Medicaid eligibility lines generated between medically needy and SSI applicants by the four-thirds formula. See especially the comments of HEW Undersecretary Wilbur Cohen, Social Security Amendments of 1967: Hearings on H.R. 12080 before the Senate Committee on Finance, 90th Cong., 1st Sess., 259, 280-282. Also telling is the fact that in 1969 congressmen introduced four bills to repeal the four-thirds AFDC payment standard and that none emerged from committee.5/

Those sources are convincing in their own right. Moreover, even if the legis-

---

5/ H.R. 618, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 69 (1969)); H.R. 1352, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 85 (1969)); H.R. 3272, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 652 (1969)); H.R. 8283, 91st Cong., 1st Sess. (introduced at 115 Cong. Rec. 5382 (1969)).

lative history had weighed against the purposefulness of the four-thirds standard, the presumptive constitutionality of Section 1903(f) would still warrant a saving construction. See Regional Rail Reorganization Act Cases, 419 U.S. 102, 134 (1974); CSC v. Letter Carriers, 413 U.S. 548, 571 (1973); Schweiker v. Wilson, 101 S.Ct. 1074, 1083 (opinion of the Court) and 1087 (dissenting opinion).

In subsequent legislation dealing with the consequences of the four-thirds standard, Congress has at least twice demonstrated its awareness and tolerance of the Medicaid eligibility differential. Later Congressional activity and enactments in pari materia may validly reflect the legislative intent of an earlier statute under examination. See especially the Court's reference to subse-

quent bills addressing the comfort allowance discrepancy challenged in Schweiker v. Wilson, 101 S.Ct. 1074, 1085 n. 22. See generally Seatrain Shipbuilding Corp. v. Shell Oil Co., 444 U.S. 572, 596 (1980): "While the views of subsequent Congresses cannot override the unmistakable intent of the enacting one, such views are entitled to significant weight, and particularly so when the precise intent of the enacting Congress is obscure."[6/]

First, in 1976 by P.L. 94-566, Title V, §503, 90 Stat. 2685, codified as 42 U.S.C. §1396a note West Supp (1980), the so called Pickle Amendment, Congress

---

6/ The Court on a number of occasions has consulted subsequent legislation for guidance, e.g., Red Lion Broadcasting Co. v. Federal Communications Commission, 395 U.S. 367, 380-381 (1969); Federal Housing Administration v. The Darlington,

(footnote continued)

provided that recipients losing SSI eligibility as a result of cost-of-living increases in their OASDI income would nonetheless preserve their concomitant Medicaid eligibility as categorically needy without any spend down requirement. In similar fashion, in 1980 by P.L. 96-272 §310, 94 Stat. 500, Congress achieved the same result for Veterans Administration pensioners by authoriza-

---

(footnote continued)

Inc., 358 U.S. 84, 90 (1958); Clark v. Ubersee Finanz-Korporation, A.G., 332 U.S. 480, 488-489 (1947); and Bailey v. Clark, 88 U.S. (21 Wall.) 284, 288 (1874). To be sure, subsequent Congressional activity will not override the plain language or clear intent of a prior enactment. See Consumer Product Safety Commission v. GTE Sylvania Inc., 100 S.Ct. 2051, 2060-2062 (1980) and Andrus v. Shell Oil Co., 100 S.Ct. 1932, 1938-1941 (1980). A convergent canon of construction is that in the formulation of an act Congress presumably has in mind previous legislation addressing the topic at hand. See Allen v. Grand Central Aircraft Co., 347 U.S. 535, 541 (1954).

tion of their waiver of cost-of-living increases otherwise disqualifying them from cash benefits and the resulting Mediciad coverage as categorically needy. Medicaid benefits. See, H.R. Rep. 96-900, 96th Cong., 2d Sess. at 68-69, reprinted in U.S. Code Cong. and Admin. News (1980) 1561, 1587-1588. Both these provisions neutralized the spend down differential at issue for the benefit of specified Medicaid recipients. They demonstrate Congressional consciousness of the complaint asserted by the present lawsuit and the legislative ability to cure the complaint in identifiable circumstances. With equal force they disprove the district court's conclusion that the four-thirds rule of Section 1903(f) survives as a "legislative accident" (J.S. 19a; 501 F.Supp. 1129, 1137).

CONCLUSION

For the foregoing reasons the Court should reverse the partial summary judgment entered by the district court.

FRANCIS X. BELLOTTI
Attorney General
MITCHELL J. SIKORA, JR.
PAUL W. JOHNSON
Assistant Attorneys General

Department of the Attorney General
2019 McCormack Building,
One Ashburton Place
Boston, MA 02108
(617) 727-1032

Dated: November 27, 1981.

Appellant's Reply Brief 2

Office - Supreme Court, U.S.
FILED
MAR 17 1982
ALEXANDER L. STEVAS,
CLERK

No. 81-213

In the Supreme Court of the United States

OCTOBER TERM, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

REPLY BRIEF FOR THE APPELLANT

REX E. LEE
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

TABLE OF AUTHORITIES

Cases: Page

Aitchison v. *Berger*, 404 F. Supp. 1137, aff'd, 538 F.2d 307, cert. denied, 429 U.S. 890 3
Brown v. *Beal*, 404 F. Supp. 770 8
Caldwell v. *Blum*, 621 F.2d 491, cert. denied, 452 U.S. 909 8
Califano v. *Boles*, 443 U.S. 282 16
Delaware Tribal Business Committee v. *Weeks*, 430 U.S. 73 14
Detroit Trust Co. v. *The Thomas Barlum*, 293 U.S. 21 2
Fabula v. *Buck*, 598 F.2d 869 8
Fedorenko v. *United States*, 449 U.S. 490 2
Freeman v. *Parham*, 475 F.2d 185 9
Fullington v. *Shea*, 404 U.S. 963, aff'g 320 F. Supp. 500 15
Hankerson v. *North Carolina*, 432 U.S. 233 1
Harrison v. *PPG Industries, Inc.*, 446 U.S. 578 12
Jenkins v. *Anderson*, 447 U.S. 231 1
Maine v. *Thiboutot*, 448 U.S. 1 ..... 13, 14
Red Lion Broadcasting Co. v. *FCC*, 395 U.S. 367 12
Rubin v. *United States*, 449 U.S. 424 12
Schaak v. *Schmidt*, 344 F. Supp. 99 8
Schweiker v. *Wilson*, 450 U.S. 221 ..... 14, 15, 17
Smith v. *Phillips*, No. 80-1082 (Jan. 25, 1982) 1
Swain v. *Pressley*, 430 U.S. 372 12

Statutes and regulations:

Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, Title XXI, 95 Stat. 783 10
Social Security Act, Title XIX, 42 U.S.C. 1396 *et seq.*:
Section 1902(a), 42 U.S.C. 1396a(a) 11
Section 1902(a)(10), 42 U.S.C. 1396a(a)(10) 3, 8
Section 1902(a)(10)(A), 42 U.S.C. 1396a(a)(10)(A) 14
Section 1902(a)(17), 42 U.S.C. 1396a(a)(17) 3, 8
Section 1902(a)(17)(D), 42 U.S.C. 1396a(a)(17)(D) 8

Statutes and regulations—Continued Page

Section 1903(f), 42 U.S.C. 1396b(f) ..... *passim*
Section 1903(f)(1)(A), 42 U.S.C. 1396b(f)(1)(A) 16
Section 1903(f)(2), 43 U.S.C. 1396b(f)(2) .. 16
Section 1903(f)(4), 42 U.S.C. 1396b(f)(4) .. 16
Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 *et seq.*:
Section 1902(a)(10), 79 Stat. 345 ..... 5, 7
Section 1902(a)(10)(A)(i), 79 Stat. 345 .... 6, 7
Section 1902(a)(10)(A)(ii), 79 Stat. 345 6
Section 1902(a)(10)(B)(i), 79 Stat. 345 6
Section 1902(a)(10)(B)(ii), 79 Stat. 345 .... 6, 7
Section 1902(a)(17), 79 Stat. 346 .....3, 4, 5, 7
Social Security Amendments of 1967, Pub. L. No. 90-248, Section 223, 81 Stat. 901-902 ..... 7, 12
Cal. Welf. & Inst. Code § 14005.13 (West Supp. 1973-1979) 11
42 C.F.R. 435.401(c) 8
42 C.F.R. 435.812 9
42 C.F.R. 435.812(a) 10
42 C.F.R. 435.812(b)(1) 11
42 C.F.R. 435.1007 11
45 C.F.R. 248.3(c)(1)(ii) (1975) 8
45 C.F.R. 248.21(a)(1)(iv) (1971) 8

Miscellaneous:

113 Cong. Rec. (1967):
p. 23055 13
p. 33170 13
p. 36312 13
p. 36319 13
118 Cong. Rec. (1972):
pp. 33982-33983 ..... 1-2, 12
p. 33983 12
46 Fed. Reg. (1981):
pp. 47979-47980 ..... 5, 10
p. 47987 10
[1980 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 30,392 11

Miscellaneous—Continued Page

H.R. 4819, 97th Cong., 1st Sess. (1981) 2
H.R. Rep. No. 213, 89th Cong., 1st Sess. (1965) ..4, 6, 7, 9
H.R. Rep. No. 544, 90th Cong., 1st Sess. (1967) 7, 13
H.R. Rep. No. 1030, 90th Cong., 1st Sess. (1967) .. 13, 16
H.R. Rep. No. 92-1605, 92d Cong., 2d Sess. (1972) .. 2, 12
H.R. Rep. No. 97-208, 97th Cong., 1st Sess. (1981) 10
S. Rep. No. 404, 89th Cong., 1st Sess. (1965) 4, 6, 7, 9
S. Rep. No. 744, 90th Cong., 1st Sess. (1967) 7
S. Rep. No. 92-1230, 92d Cong., 2d Sess. (1972) 9

In the Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-213

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, APPELLANT

v.

GEORGE HOGAN, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

REPLY BRIEF FOR THE APPELLANT

---

1. Although they have not completely abandoned their constitutional argument, appellees (Br. 12-34) now urge this Court to affirm the district court's judgment on statutory grounds—essentially by amending the plain language of Section 1903(f) of the Act (42 U.S.C. 1396b (f)).[1] The modification appellees suggest is virtually identical to the amendment of Section 1903(f) that Congress refused to adopt in 1972 (see 118 Cong. Rec. 33982-

[1] For present purposes we assume that appellees' statutory argument is properly raised in this Court. See, *e.g.*, *Smith* v. *Phillips*, No. 80-1082 (Jan. 25, 1982), slip op. 5 n.6. Nevertheless, since appellees failed to raise this argument in the lower court (Br. 10 n.5), it need not be considered here. See, *e.g.*, *Jenkins* v. *Anderson*, 447 U.S. 231, 234-235 n.1 (1980); *Hankerson* v. *North Carolina*, 432 U.S. 233, 240 n.6 (1977).

33983 (remarks of Sen. Tunney); H.R. Rep. No. 92-1605, 92d Cong., 2d Sess. 61) and 1981 (see H.R. 4819, 97th Cong., 1st Sess.). Congress may yet accept appellees' arguments and amend Section 1903(f). There is, however, no basis for "interpreting" Section 1903(f) as if it read 133⅓% of the relevant AFDC payment amount "or 100% of the combined SSI-state supplementary payment level, whichever is higher." To accept appellees' statutory argument "'is not to construe the Act but to amend it.'" *Fedorenko* v. *United States*, 449 U.S. 490, 513 (1981), quoting *Detroit Trust Co.* v. *The Thomas Barlum*, 293 U.S. 21, 38 (1934).

Appellees contend that in 1965 Congress enacted an "income comparability requirement" (Br. 13) that prohibited the states from setting "medically needy standards below the corresponding cash assistance standards" (*ibid.*). Because the 1967 amendments to the Medicaid Act did not describe the limitation on federal financial assistance for providing Medicaid benefits to the medically needy established by Section 1903(f) as a modification of "comparability," appellees conclude Congress must have been unaware that Section 1903(f) might sometimes require the medically needy to incur medical expenses in excess of the difference between their incomes and the pertinent categorical assistance income limits. That is, Congress simply "did not recognize" (Br. 12) that Section 1903(f) might modify the "income comparability requirement" by sometimes requiring the states to set "medically needy standards below the corresponding cash assistance standards." Congress, therefore, could not have intended this result, and appellees urge this Court to interpret Section 1903(f) to reach the result Congress would have achieved if it had only been more attentive.

We readily acknowledge that the legislative history of the Medicaid Act, although not unambiguous, suggests that in 1965 Congress intended that medically needy spend down standards be set no lower than some cash

assistance income limitation. See pages 8-11, *infra*; see also Gov't Br. 22 n.25. Indeed, the Secretary consistently required that each state set its medically needy spend down standard at an amount equal to the highest of its cash assistance income limitations, *except when Section 1903(f) required a lower medically needy standard.* See note 7, *infra.* As we understand it, appellees' statutory argument depends in large part on the erroneous assumption that Congress regarded this limitation on the medically needy spend down level as an "income *comparability* requirement." Otherwise, Congress' decision to label one of the 1967 amendments a modification of "comparability" but not Section 1903(f) would be of absolutely no significance. Even if that assumption were not so clearly wrong, Congress' decision to label Section 1903(f) a "Limitation on Federal Participation in Medical Assistance" rather than a modification of "comparability" would provide no basis for ignoring the plain language of Section 1903(f) and the Secretary's consistent interpretation of that provision. Because so much of appellees' argument turns on this point, however, we take the time to respond.

a. Appellees first cite Section 1902(a)(17) of the Act (42 U.S.C. 1396a(a)(17)) as the provision establishing the "income comparability requirement" that prohibited medically needy standards lower than the relevant cash assistance income limits in 1965 (Br. 12-13). Appellees also assert (Br. 16), however, that this "income comparability requirement" was established in Section 1902(a)(10) of the Act (42 U.S.C. 1396a(a)(10)).

As adopted in 1965, Section 1902(a)(17) of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 346, provided, in pertinent part, that all state Medicaid plans "include reasonable standards (which shall be comparable for all groups) for determining eligibility for and the extent of medical assistance under the plan * * *." Congress' purpose in adopting this provision was to insure "comparability" among the four categories of potential Medicaid

beneficiaries and not between the categorically needy and the medically needy:

> Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards * * *. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a *comparability among the various categorical groups of needy people.* Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

H.R. Rep. No. 213, 89th Cong., 1st Sess. 67 (1965) (emphasis added); see S. Rep. No. 404, 89th Cong., 1st Sess. 77-78 (1965). As understood in 1965, the "comparability" required by Section 1902(a)(17), precluded a state from, for example, setting one medically needy "spend down" level [2] for families with dependent children and

---

[2] For convenience, we use the term "spend down level." It should be emphasized, however, that the medically needy only have to *incur* medical expenses of the requisite amount and that eligibility is not dependent upon actual payment of the expenses during any particular period of time. Thus, a medically needy individual may never in fact be left with less money for nonmedical expenses in any given month than a categorically needy individual, even if the spend down level is lower than the cash assistance level.

For example, if the monthly cash assistance income standard is $525 and the medically needy spend down level is $400, an individual with monthly income of $600 would have to incur at least $200 of medical expenses to qualify for Medicaid benefits. See Gov't Br. 6 n.9. If he paid the entire bill in a single month he would be left with $400 for nonmedical expenses in that month. But if he paid the $200 bill over a 10 month period at a rate of $20 per month, he would retain $580 per month for nonmedical expenses.

another far more generous spend down level for the aged.[3] The "comparability" clause of Section 1902(a)(17) simply cannot—consistent with its legislative history—be read to prohibit a state from establishing a medically needy spend down level that is lower than related cash assistance income limits.

Similarly, the "comparability" required by Section 1902(a)(10) cannot be read to preclude medically needy spend down levels that are lower than the related cash assistance income limits. As enacted in 1965, Section 1902(a)(10) required all participating states to (79 Stat. 345):

> provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI; and—
>
> (A) provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan—
>
> (i) shall not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such State plan, and
>
> (ii) shall not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals not receiving aid or assistance under any such plan; and
>
> (B) if medical or remedial care and services are included for any group of individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide—

---

[3] The 1981 amendments to the Act appear to have modified this requirement. See generally 46 Fed. Reg. 47979-47980 (1981).

> (i) for making medical or remedial care and services available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care and services, and
>
> (ii) that the medical or remedial care and services made available to all individuals not receiving aid or assistance under any such State plan shall be equal in amount, duration, and scope.

Nothing in this provision prohibits medically needy spend down levels that are lower than cash assistance income limits. Each participating state must cover all cash assistance recipients, and the services provided to each group of cash assistance recipients must be the same. Section 1902(a)(10)(A)(i); see H.R. Rep. No. 213, *supra*, at 66, 184; S. Rep. No. 404, *supra*, at 77. The states are prohibited from providing more extensive services to the medically needy than to the categorically needy. Section 1902(a)(10)(A)(ii); see H.R. Rep. No. 213, *supra*, at 66-67, 184; S. Rep. No. 404, *supra*, at 77. If the state chooses to adopt a medically needy program, the services provided to each group of the medically needy must be the same. Section 1902(a)(10)(B)(ii); see H.R. Rep. No. 213, *supra*, at 67, 184; S. Rep. No. 404, *supra*, at 77. Also, if a state that has cash assistance plans for each of the four groups covers any group of medically needy individuals, it is required to cover all four groups, and the spend down level for each group must be "comparable" to that established for each of the other medically needy groups. Section 1902(a)(10)(B)(i); see H.R. Rep. No. 213, *supra*, at 67, 184; S. Rep. No. 404, *supra*, at 77.[4]

---

[4] Although the language of Section 1902(a)(10)(B)(i) is somewhat ambiguous, the legislative history of the provision leaves no

Thus, to the extent appellees' statutory argument depends on Congress' failure to describe Section 1903(f) as a modification of the "income comparability requirement" established in either Section 1902(a)(10) or Section 1902(a)(17), it is wholly untenable. Those provisions prescribed "comparability" among the four groups of potential Medicaid beneficiaries and not comparability between the categorically needy and the medically needy. Section 1903(f) did not modify those comparability requirements.[5] Therefore, Congress' failure to label Section 1903(f) a modification of comparability provides no support for appellees' argument that the

---

doubt as to what Congress intended (H.R. Rep. No. 213, *supra*, at 67; emphasis added):

> Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is *comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs.* Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC.

See S. Rep. No. 404, *supra*, at 77.

[5] Indeed, the provision that Congress did label a "Modification of Comparability Provisions" (Social Security Amendments of 1967, Pub. L. No. 90-248, Section 223, 81 Stat. 901-902) in 1967 confirms the analysis set out above. Section 223 of the 1967 amendments provided that if a state purchased optional Medicare benefits or paid certain other Medicare expenses for the aged under its Medicaid program it would not be required to provide benefits of the same scope to any other groups, notwithstanding the requirements of Section 1902(a)(10)(A)(i) and Section 1902(a)(10)(B)(ii). See H.R. Rep. No. 544, 90th Cong., 1st Sess. 119-121 (1967); S. Rep. No. 744, 90th Cong., 1st Sess. 180-181 (1967). Since Section 1903(f) only prescribed different standards of financial eligibility for the medically needy and the categorically needy and not differences among the categorically needy or among the medically needy, Congress' failure to describe it as a modification of any comparability provision is not surprising.

legislators were unaware that the provision might sometimes require a medically needy applicant to incur medical expenses in excess of the difference between his income and the relevant cash assistance income limit.[6]

b. As we have demonstrated, in 1965 Congress did not require states having medically needy programs to establish or maintain "comparability" between the income limits established for the categorically needy and the spend down levels established for the medically needy. Nevertheless, in 1965 Congress seems to have intended to limit the amount of medical expenses the medically needy could be required to incur.

If a state chooses to adopt a medically needy program, the second clause of Section 1902(a)(17)(D) (42 U.S.C. 1396a(a)(17)(D)) requires the state to "provide

---

[6] With one arguable exception (see *Brown* v. *Beal*, 404 F. Supp. 770 (E.D. Pa. 1975)), none of the cases relied upon by appellees (Br. 13) even suggests that the "comparability" requirements of either Section 1902(a)(10) or Section 1902(a)(17) prohibit medically needy spend down levels that are lower than the corresponding categorical assistance income limits. Both *Caldwell* v. *Blum*, 621 F.2d 491 (2d Cir. 1980), cert. denied, 452 U.S. 909 (1981), and *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979), involved transfer-of-assets rules that violated express HHS regulations precluding non-financial eligibility requirements for the medically needy that were more restrictive than those applicable to the categorically needy (see 42 C.F.R. 435.401(c)). *Schaak* v. *Schmidt*, 344 F. Supp. 99 (E.D. Wis. 1971) is similar: the court invalidated a limitation on permissible home equity that violated 45 C.F.R. 248.21(a)(1)(iv) (1971).

In *Aitchison* v. *Berger*, 404 F. Supp. 1137 (S.D.N.Y. 1975), aff'd, 538 F.2d 307 (2d Cir.), cert. denied, 429 U.S. 890 (1976), the court held that the state medically needy spend down level was lower than the highest cash assistance income limit and, therefore, invalid under 45 C.F.R. 248.3(c)(1)(ii) (1975). The court also found the regulation consistent with the Medicaid Act.

In *Brown* v. *Beal*, 404 F. Supp. 770 (E.D. Pa. 1975), the court appears to have held that any state that adopts a medically needy program must treat the medically needy as if they were categorically needy when their income net of incurred medical expenses is less than the related cash assistance program income limit.

for flexibility in the application of [its financial eligibility] standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law." See *Freeman* v. *Parham*, 475 F.2d 185 (5th Cir. 1973). In describing this provision in 1965, Congress explained (H.R. Rep. No. 213, *supra*, at 68):

> The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles * * * may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be $2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than $2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

See S. Rep. No. 404, *supra*, at 78-79.

It is far from clear that the "test of eligibility under the State plan," mentioned in this passage, referred to the income limits established under the state cash assistance plans. As we have already explained, Congress plainly intended to prevent the states from establishing, for example, one medically needy spend down level for families with dependent children and another more generous spend down level for the aged. Yet, there have always been great disparities among the income limits set by the states under the categorical assistance programs for the aged, blind, disabled, and families with dependent children. See, *e.g.*, S. Rep. No. 92-1230, 92d Cong., 2d Sess. 78-81, 118-119 (1972). Given these gross disparities between the categorical assistance plan income

limits set for the aged and those set for families with dependent children, Congress' intention to require "comparability" between the medically needy spend down levels for these two groups could not be achieved if the "test of eligibility" mentioned in the committee reports referred to the categorical assistance income limits for the groups rather than the spend down levels the states set under their Medicaid programs. Nonetheless, the Secretary required each state to set a single medically needy spend down level that was at least as high as the highest of its cash assistance levels. See, *e.g.*, 42 C.F.R. 435.812. In those states with widely varying income limits for the categorically needy this is the lowest *minimum* medically needy spend down level that would be consistent with the clear requirement that the spend down level be "comparable" for all groups of the medically needy and with Congress' apparent intention to preclude medically needy spend down levels that were lower than corresponding cash assistance income limits.[7]

Contrary to appellees' assertion (Br. 14-15 n.8, 32 n.21), the Secretary has consistently recognized that if establishing a medically needy spend down level at the highest of the cash assistance income limits (as required by his regulations) would result in a medically needy spend down level in excess of that prescribed in Section 1903(f), the states were not required to do so. Instead, the states could set their medically needy spend down

---

[7] Following the enactment of the 1981 amendments to the Act (Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, Title XXI, 95 Stat. 783), the Secretary eliminated the general requirement that the spend down level be at least as high as the highest cash assistance level. See 46 Fed. Reg. 47979-47980, 47987 (1981). In light of Congress' expressed intention to give the states greater flexibility to structure their medically needy programs (H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 971 (1981)), the Secretary's regulations now only require that the states establish "reasonable" medically needy standards. 46 Fed. Reg. 47987 (1981), to be codified at 42 C.F.R. 435.812(a). The regulations also provide that certain medically needy spend down levels are presumptively "reasonable." 46 Fed. Reg. 47979-47980, 47987 (1981).

level in accordance with Section 1903(f). Indeed, the Secretary's regulation expressly stated that the states may "use a lower [medically needy] standard" if the highest of the cash assistance income limits was higher than the limitation imposed in Section 1903(f). 42 C.F.R. 435.812(b)(1).[8]

c. Whatever Congress' view may have been in 1965, it is manifest that in 1967 Congress perceived no necessary relationship between the income limits established for the categorically needy and the spend down levels set for the medically needy. Appellees respond (Br. 26, 30) that the "only" factor that supports the Secretary's interpretation of Section 1903(f) is "the language" of the provision. We submit that no more

---

[8] Appellees assert (Br. 14-15 n.8) that "the Secretary has allowed the California Medicaid plan to employ an income disregard which has the effect of raising the medically needy standards for the aged and disabled above the four-thirds maximum in order to achieve comparability with the California SSI standards. *See* California Welfare and Institutions Code § 14005.3(b)-(d)." The statute cited does not establish an income disregard or deduction of any kind. We presume that appellees intended to refer to Cal. Welf. & Inst. Code § 14005.13 (West Supp. 1973-1979), which does establish a special income deduction for the aged, blind, and disabled medically needy. We are informed that the Secretary has never approved this provision and that it is not included in California's Medicaid Plan. See generally 42 U.S.C. 1396a(a). California Medicaid officials repeatedly have been informed that the provision is inconsistent with federal law and that if the special deduction results in a medically needy spend down level in excess of that prescribed in Section 1903(f) and the Secretary's regulations (42 C.F.R. 435.1007), no federal financial assistance is available.

Appellees also cite (Br. 14 n.8) HCFA Regional Office Manual [1980 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 30,392, at 9521-9522, as suggesting inconsistency in the Secretary's interpretation of Section 1903(f). That transmittal is totally irrelevant to this case. It simply recognizes that the amount that would be paid to a family of two under a state AFDC program would be higher if the family consisted of two adults (if there were such a category under the AFDC program) than if it included an adult and a child.

is required. See, *e.g.*, *Rubin* v. *United States*, 449 U.S. 424, 429-430 (1981); *Swain* v. *Presley*, 430 U.S. 372, 378 (1977). Congress need not "state in committee reports or elsewhere in its deliberations that which is obvious on the face of a statute." *Harrison* v. *PPG Industries, Inc.*, 446 U.S. 578, 592 (1980). If more were required, however, it would not be lacking in this case.

We begin with a proposition that appellees concede (Br. 32), namely: "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong * * *" (*Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367, 381 (1969)). This principle applies with even greater force when Congress has specifically considered but declined to change the statute (*ibid.*), as in this case. See 118 Cong. Rec. 33982-33983 (remarks of Sen. Tunney) (1972); H.R. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972). We have already described the legislative history of Section 1903(f) in some detail (Gov't Br. 24-37), and there is no need to reiterate that discussion here. It is sufficient to emphasize that Section 1903(f)—though only a small part of the Social Security Amendments of 1967—was recognized as a very significant provision and was hotly debated. The information before Congress plainly showed that in 28 states 133⅓% of the AFDC payment amount for one person would be less than the Medicaid income limits applicable to the categorically needy. See Gov't Br. App. 1a-4a.[9]

---

[9] Appellees complain (Br. 21-22) that there is no evidence that any legislator actually performed the arithmetic necessary to make a chart of the sort set out in our brief at Appendix 1a-4a. See also 118 Cong. Rec. 33983 (1972). But appellees do not dispute the fact that the evidence was before Congress; nor do they seriously challenge the accuracy of the chart. Moreover, it was not necessary for anyone to undertake the arithmetic upon which our chart is based in order to recognize the significance of Section 1903(f). Even appellees acknowledge (Br. 18-20) that Congress was fully aware that some states paid only a fraction of the standard of need

Yet, Congress enacted Section 1903(f), which, by its express terms, is applicable to the medically needy but not to the categorically needy. Appellees respond by repeatedly asserting that Congress was simply ignorant of what it obviously was doing—that "had Congress been more careful, and had it fully thought out the relationship among the various sections, it might have acted differently." *Maine* v. *Thiboutot*, 448 U.S. 1, 8 (1980) (footnote omitted).[10]

---

established under their AFDC programs and, therefore, that in those states 133⅓% of the AFDC payment might be less than the standard of need established under even the AFDC program. It cannot be disputed that Congress was also aware that the AFDC standards were generally the lowest of all the cash assistance standards (see, *e.g.*, H.R. Rep. No. 544, *supra*, at 119; 113 Cong. Rec. 23055 (1967) (remarks of Rep. Mills)) and that the OAA assistance standards were generally the highest (see, *e.g.*, 113 Cong. Rec. 33170 (1967) (remarks of Sen. Long)). Therefore, in any state that paid less than 75% of the AFDC standard of need, 133⅓% of the payment amount would be less than 100% of the AFDC standard of need and, in most states, less than 100% of the standard of need (and corresponding income limits) established under the OAA cash assistance program. Appellees label this (Br. 20) the "below need" problem. Applying the 133⅓% limitation to the medically needy but not to the categorically needy inevitably resulted in the "discrimination problem" of which appellees complain.

[10] It is unnecessary to respond to any of appellees' bald assertions of legislative mistake, but two of them deserve comment. As we have pointed out (Gov't Br. 36), one of the Senate conferees expressly stated that none of the categorically needy would be affected by the conference bill (113 Cong. Rec. 36319 (1967) (remarks of Sen. Curtis)), and the *Summary of Social Security Amendments of 1967* prepared by the Senate Committee staff made precisely the same point (113 Cong. Rec. 36312 (1967)), as did the conference report. See H.R. Rep. No. 1030, 90th Cong., 1st Sess. 63 (1967). Nevertheless, appellees assert (Br. 23-24) that Senator Kennedy, who had explicitly criticized the House bill because of its impact on medically needy spend down levels (see Gov't Br. 32-33), was unaware that the bill, as amended in Conference, only applied to the medically needy. To us that seems unlikely.

Appellees also assert (Br. 21) that Representative Burton criticized the House version of Section 1903(f) only because of its effect on "people who want Medicaid and would be eligible for

This Court has consistently rejected similar arguments made by parties who have attempted to win in litigation battles that have been lost in the legislature. See *Schweiker* v. *Wilson*, 450 U.S. 221 (1980); *Maine* v. *Thiboutot*, *supra*; *Delaware Tribal Business Committee* v. *Weeks*, 430 U.S. 73 (1977). Appellees' assertions of ignorance on the part of the entire Congress are incredible; they certainly provide no basis for ignoring the plain language of the statute.

2. We now turn briefly to appellees' constitutional argument. Congress enacted Section 1903(f) to reduce federal Medicaid expenditures (Gov't Br. 16-17). As the legislative history of the provision makes abundantly clear, the reason for the distinction drawn between the categorically needy and the medically needy in Section 1903(f) is precisely the same as that which supports

---

it as categorically needy if they would apply for cash assistance but who are 'too proud' to do so * * *." But appellees then state (Br. 21 n.11) that "[i]t is not clear how Representative Burton thought the income limitation would affect this problem," suggesting that he did not understand the provision.

Representative Burton clearly assumed that the 133⅓% AFDC payment amount limitation would be inapplicable to cash assistance recipients because Section 1902(a)(10)(A) required participating states to provide Medicaid benefits to anyone receiving cash assistance. He began by stating that the proposed Medicaid limitations were (App., *infra*, 1a) "absolutely contrary to the original title XIX legislative intent," which was "to provide the medically indigent an equivalent degree of medical care provided public assistance recipients * * *." A Social Security benefit recipient "too proud" to accept Old Age Assistance could nonetheless qualify for Medicaid as medically needy. If 133⅓% of the relevant AFDC payment amount is greater than the Old Age Assistance income limit, the "too proud" Social Security benefit recipient would not have to incur any medical expenses to qualify for Medicaid as medically needy. On the other hand, if 133⅓% of the AFDC payment amount is less than the OAA income limit, then the "too proud" Social Security benefit recipient will have to incur some medical expenses before he qualifies for Medicaid as medically needy and to that extent will be precluded by Section 1903(f) from "getting equivalent medical care that is received by * * * OAA" recipients (App., *infra*, 1a).

the many other distinctions between these two groups throughout the Medicaid program: because they have more money before medical expenses are incurred, the medically needy are generally better able than the categorically needy to insure against possible future medical expenses.[11] Accordingly, there is no basis for deviating from the equal protection standard traditionally applied in evaluating social welfare legislation. Compare *Schweiker* v. *Wilson*, 450 U.S. 221, 244-245 (1981) (Powell, J., dissenting).

Appellees concede (Br. 38) that if the relevant distinction is between the categorically needy (*i.e.*, those people who have income that is less than the cash assistance limits) and the medically needy (*i.e.*, those people whose income *before deduction of medical expenses* is greater than the cash assistance limits), this Court's decisions "support" reversal. That, we submit, is the only relevant distinction; indeed, if Congress and the states may not compare the two groups prior to the deduction of medical expenses, for the purpose of determining eligibility for Medicaid, then every participating state would be required to have a medically needy program, and *Fullington* v. *Shea*, 404 U.S. 963 (1971), would have been wrongly decided.

In Section 1903(f) of the Social Security Act, Congress expressly distinguished between the categorically

---

[11] The most important distinction between the categorically needy and the medically needy, of course, is that participating states are required to provide Medicaid benefits to the categorically needy but not to the medically needy. 42 U.S.C. 1396a(a)(10). In light of *Fullington* v. *Shea*, 404 U.S. 963 (1971), aff'g 320 F. Supp. 500 (D. Colo. 1970), appellees concede the constitutional validity of that distinction, but argue that having decided to permit the medically needy to qualify for Medicaid benefits by deducting medical expenses, Congress was then constitutionally required to ignore the real differences between the two groups, as well as the obvious difference between an absolute income limitation and a flexible spend down level. There is absolutely nothing in this Court's decisions that provides any support for that argument (see Gov't Br. 38-42).

needy and the medically needy. Section 1903(f)(4) provides that "[t]he limitations on payment imposed by the preceding provisions * * * shall not apply with respect to any amount expended by a State as medical assistance for any individual" whose *gross income* is less than the limits established under the cash assistance programs. To the extent relevant here, the *only* distinction established in Section 1903(f) is between the categorically needy and the medically needy. See H.R. Rep. No. 1030, 90th Cong., 1st Sess. 63 (1967). Accordingly, that is "the proper classification for purposes of equal protection analysis." *Califano* v. *Boles*, 443 U.S. 282, 293-294 (1979).[12]

The distinction between the categorically needy and the medically needy established in Section 1903(f) rests on the common sense proposition that because the medically needy have more income than the categorically needy at the relevant time (*i.e.*, before medical expenses

---

[12] "Only when it is shown that the legislation has a *substantial disparate impact* on classes defined in a different fashion may analysis continue on the basis of the impact on those classes." *Califano* v. *Boles*, 443 U.S. 282, 293-294 (1979) (emphasis added). No such showing has been made here; appellees, of course, do not contend that the distinction established in Section 1903(f) was a veiled attempt to discriminate against Social Security benefit recipients. Since there are doubtless many Social Security benefit recipients who also receive SSI or state supplementary payment benefits and are, therefore, within the favored class, such a contention would be untenable in any event.

Relying on the method of measuring income prescribed in Section 1903(f)(2), appellees contend (Br. 37-39) that the relevant comparison is between the categorically needy and aged or disabled Social Security recipients whose income *net of medical expenses* is less than the income limits established for the categorically needy. That classification, of course, "frame[s] the constitutional issue in [the] manner most favorable to their claim" (*Califano* v. *Boles*, *supra*, 443 U.S. at 293), but it bears no relation to the distinction Congress made. Section 1903(f)(2) is just what it purports to be, namely, the method for determining whether the income limitation prescribed in Section 1903(f)(1)(A) is satisfied; it does not create any classification.

are incurred) they are *generally better* able to provide for their own medical expenses—by purchasing insurance or otherwise—than the categorically needy.[13] Faced in 1967 with what it regarded as a compelling need to limit federal expenditures under the Medicaid program, Congress chose to concentrate limited funds where the need was thought to be greatest. See, *e.g.*, *Schweiker* v. *Wilson*, 450 U.S. 221, 238-239 (1981). There is no constitutional impediment to this reasonable legislative judgment.

For the foregoing reasons and the additional reasons set forth in the brief for the appellant, the judgment of the district court should be reversed.

REX E. LEE
Solicitor General

MARCH 1982

---

[13] We are baffled by appellees' claim (Br. 42) that the government has abandoned these arguments in support of the statute. As we explained in our opening brief (Gov't Br. 18-19), Section 1903(*f*) effectively increases the "cost" to the medically needy of obtaining Medicaid benefits and thus encourages those who are generally in a better position to do so to purchase private insurance (and, in the case of most if not all of the appellees, to purchase optional Medicare coverage). Contrary to appellees' contention (Br. 42-48), encouraging the medically needy to purchase private insurance and Medicare is a perfectly rational means of reducing Medicaid expenditures. Medical expenses paid by a private insurer or under the Medicare program are expenses that will not be paid under the Medicaid program. Insurance premiums may be deducted from gross income so that a medically needy individual may qualify for Medicaid, but only those covered medical expenses that are not paid by the private insurer will be paid under the Medicaid program. As to private insurance, see also Gov't Reply to the Motion to Affirm at 7-8; as to optional Medicare coverage, see also *id.* at 9-10.

Appendix

APPENDIX

REMARKS OF REPRESENTATIVE BURTON *

Let me get to another matter. The proposed title XIX amendments, contrary to that which has been said on this floor, are absolutely antagonistic to the legislative history and the thrust of the Kerr-Mills Act. They are absolutely contrary to the original title XIX legislative intent. The intent of title XIX and the Kerr-Mills Act was to provide the medically indigent an equivalent degree of medical care provided public assistance recipients under PAMC—some means by which they could receive medical care benefits. The medically indigent by definition were those whose income did not permit them to qualify for a public assistance grant, but whose income was so limited they would not be able to meet medical costs in addition to minimum nonmedical expenses.

What position are we in with this bill? It is going to reduce Federal contributions under title XIX to California—in the next few years—by $200 to $300 million per year.

What else will it do? If one is on old-age assistance in the State of California, the average income is about $150 a month. For a married couple it can be $300 a month, if they are on old-age welfare. What if one is too proud to take welfare and the combined social security benefits between the husband and wife are a lesser amount than that which they would receive on welfare?

Under the proposed title XIX income limitation we have people drawing old-age security benefits—whose income is less than someone drawing old-age assistance, and they will be precluded—under the clear language of this bill—from getting equivalent medical care that is received by their better-off counterparts on OAA. I do not think that is a thoughtful legislative product.

---

* 113 Cong. Rec. 23092 (1967).

My colleagues, I have made a number of statements. It can be demonstrated, if someone chooses to take issue with them, whether I have misstated the case or not. I have a few minutes of my time left, which I will not yield back. However, I invite anyone to take issue with those statements.

In the absence of being questioned, I assume—in the record—they will have to remain unchallenged.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1982 388933 933

Amicus Brief

Office - Supreme Court, U.S.
FILED
JAN 20 1982
ALEXANDER L. STEVAS,
CLERK

No. 81-213

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1981

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Appellant,

vs.

GEORGE HOGAN, ET AL.,

Appellees.

ON APPEAL FROM
THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

[redacted]

BRIEF AMICUS CURIAE OF THE MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS IN SUPPORT OF APPELLEES

Of Counsel
DENNIS CARAHER
WESTERN NEW ENGLAND
COLLEGE
School of Law
Springfield, MA 01119
(413) 782-3111

BRUCE K. MILLER
WESTERN NEW ENGLAND
COLLEGE
School of Law
Springfield, MA 01119
(413) 782-3111

Counsel for Amicus Curiae

TABLE OF CONTENTS

page

Table of Authorities ii

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE 1

BRIEF AMICUS CURIAE 5

Interest of Amicus 5

Summary of Argument 5

Argument 10

I. THE "FOUR-THIRDS" AMENDMENT MAY CONSTITUTIONALLY BE APPLIED AGAINST THE HOGAN CLASS ONLY IF SUCH APPLICATION BEARS A FAIR AND SUBSTANTIAL RELATION TO THE PURPOSES ASSERTED BY THE SECRETARY . . . 10

II. THE APPLICATION OF THE "FOUR-THIRDS" AMENDMENT TO THE HOGAN CLASS DOES NOT BEAR A FAIR AND SUBSTANTIAL RELATION TO THE PURPOSE ASSERTED BY THE SECRETARY 20

Summary Conclusion 29

TABLE OF AUTHORITIES

CASES	Page
Brown v. Board of Education 347 U.S. 483 (1954)	11
Califano v. Westcott 443 U.S. 76 (1979)	11
Califano v. Yamasaki 442 U.S. 682 (1979)	4
Dandridge v. Williams 397 U.S. 471 (1970)	10
Flemming v. Nestor 363 U.S. 603 (1960)	12, 15
F.S. Royster Guano Co. v. Virginia 253 U.S. 412 (1920)	6, 13, 18
Hogan v. Harris 501 F.Supp. 1129 (D.Mass. 1980)	17
James v. Strange 407 U.S. 128 (1972)	13
Jimenez v. Weinberger 417 U.S. 608 (1974)	11
Lindsley v. Natural Carbonic Gas Co. 20 U.S. 61 (1911)	6, 12, 13
Mathews v. Lucas 427 U.S. 495, (1976)	20
McGinnis v. Royster 410 U.S. 263 (1973)	13

McGowan v. Maryland
366 U.S. 420 (1961) 12

Schweiker v. Wilson
450 U.S. 221 (1981) 6, 7, 11
14, 15, 17, 20, 21, 22, 23, 25

Shapiro v. Thompson
394 U.S. 618 (1969) 11

U.S. Department of Agriculture v. Moreno
413 U.S. 528 (1973) 11

U.S. Railroad Retirement Board v. Fritz
449 U.S. 166 (1980)
6, 7, 12, 13, 14, 15

STATUTES

United States Code, Title 42, §601 21

United States Code, Title 42, §1381 21

Social Security Act, §1903(f)
42 U.S.C. §1396b(f) 16, 21, 29

RULES

Rules of the United States Supreme Court
Rule 36(2) 2
Rule 42(1) 1

MISCELLANEOUS

H.R. Rep. No. 213, 89th Cong.,
1st Sess. (1965) 29

S. Rep. No. 92-1230, 92nd Cong.,
2nd Sess. (1972) 24

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981
NO. 81-213

RICHARD S. SCHWEIKER, SECRETARY
OF HEALTH AND HUMAN SERVICES,
APPELLANT,

v.

GEORGE HOGAN, ET AL.,
APPELLEES.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT
OF MASSACHUSETTS

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE OF THE MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS IN SUPPORT OF APPELLEES

TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

The Massachusetts Association of Older Americans (MAOA) respectfully moves this court, pursuant to Supreme Court Rule 42(1), for leave to file the brief which

accompanies this motion as amicus curiae in support of the appellees. In support of this motion, MAOA submits the following statement outlining its interest in the issues presented by this appeal:

1. Appellees have consented to MAOA's request to submit a brief amicus curiae in support of their position. By letter dated January 12, 1982, to Kenneth Geller, Deputy Solicitor General, MAOA has requested the consent of the appellant, the Secretary of Health and Human Services, to the filing of its brief. MAOA expects that the Secretary will also grant his consent. MAOA further expects that letters reflecting the consent of both parties will be filed with the Court, pursuant to Supreme Court Rule 36(2), by January 18, 1982.

2. The Massachusetts Association of Older Americans is a nonprofit corporation

organized under the laws of Massachusetts. It is the largest statewide organization of elderly residents of Massachusetts. Presently, its members number 18,000, each of whom resides in Massachusetts and is over 60 years of age. A large number of MAOA members are eligible for Medicaid benefits by virtue of their receipt of SSI or as medically needy persons. MAOA and its members thus have a direct interest in the disposition of the issues presented by this appeal.

3. MAOA submits that its views may be especially helpful to the Court in resolving this appeal. One of the topics likely to be addressed by the Court in its review of the decision of the district court is the proper scope of judicial review, under the equal protection guarantee of the Fifth Amendment, of a legislative

classification that is supported by no purpose articulated in the history or structure of the statute which enacted it. MAOA's brief is addressed exclusively to this question.

4. The perspectives of MAOA on the issues presented by this litigation are augmented by the experience of their counsel who has presented briefs to this Court on behalf of amicus parties in numerous cases involving the rights of the elderly. One of these cases is Califano v. Yamasaki, 442 U.S. 682 (1979).

WHEREFORE, the MAOA respectfully moves this Court to grant it leave to file the Brief of Amicus Curiae which accompanies this motion.

Respectfully submitted,

BRUCE K. MILLER
Counsel for Amicus Curiae
Massachusetts Association
of Older Americans

Of Counsel
DENNIS CARAHER

BRIEF AMICUS CURIAE OF THE MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS

INTEREST OF AMICUS

A statement describing the Massachusetts Association of Older Americans and its interest in this case is set forth in the preceding motion requesting leave to file this amicus curiae brief.

SUMMARY OF ARGUMENT

A statutory classification in the social welfare area that neither harms a suspect or traditionally disadvantaged class nor abridges a fundamental right must be sustained by this Court so long as it advances legitimate legislative goals in a rational fashion. The proper method for applying this standard has been a matter of continuing debate in this Court's opinions. Sometimes, the Court has sustained classification challenged as

violative of equal protection values so long as they could be plausibly supported by any conceivable state of facts. Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78-79 (1911). On other occasions, the Court has required more -- demanding, for example, that a statutory discrimination bear a fair and substantial relation to the object of the legislation that produced it. F.S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920).

The tension between these two approaches which surfaced most recently in the Court's opinions last term in U.S. Railroad Retirement Board v. Fritz, 449 U.S. 166 (1980); and Schweiker v. Wilson, 450 U.S. 221 (1981), is rooted in two very different conceptions of the role of articulated legislative purpose in "rational basis" review. In Fritz, the presence of such

articulated purpose was irrelevant; in Wilson, it was a critical premise of the Court's reasoning in sustaining the classification at issue.

Amicus contends that the present case, by presenting for review a classification shown to have been inadvertently enacted, provides an appropriate opportunity for the Court to resolve the uncertainty which inevitably follows Fritz and Wilson. A proper resolution may be drawn from the standard proposed by Justice Powell's dissenting opinion in Wilson, supra, 450 U.S. at 239. Amicus submits that this standard, which would sustain a classification enacted without an identifiable contemporaneous purpose only if it bears a "fair and substantial relation" to any subsequent purpose introduced in litigation, presents an approach to "rational basis"

review that is consistent both with judicial deference to legislative policy choices and with this Court's role as guarantor of equal protection values.

Application of the so-called "four-thirds of AFDC" standard, section 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f), to medically needy aged and disabled people does not satisfy the "fair and substantial relation" standard. The classification is supported by no identifiable legislative purpose. The Secretary nevertheless contends that it encourages the medically needy to buy private health insurance as a substitute for Medicaid. This argument ignores the fact that the private insurance generally available to aged and disabled is both too costly for people with incomes near (although above) the subsistence levels provided by the

Supplemental Security Income program (SSI) and far less comprehensive in coverage than is Medicaid. The punishment imposed by the four-thirds rule thus provides no incentive to purchase private health insurance. The rule is tied by no logical link to its supposed purpose and should therefore be invalidated.

ARGUMENT

I. THE "FOUR-THIRDS" AMENDMENT MAY CONSTITUTIONALLY BE APPLIED AGAINST THE HOGAN CLASS ONLY IF SUCH APPLICATION BEARS A FAIR AND SUBSTANTIAL RELATION TO THE PURPOSES ASSERTED BY THE SECRETARY.

In our constitutional scheme of representative government, legislative judgments concerning the allocation of public funds to social welfare programs are not ordinarily subject to revision by the federal courts. As this Court observed in Dandridge v. Williams, 397 U.S. 471 (1970), the Constitution grants the federal courts "no power to impose . . . their views of what constitutes wise economic or social policy. [The] intractable economic, social and even philosophical problems presented by public welfare assistance programs are not the business of this court." 397 U.S. at 485-86.

Barring discrimination against a suspect or traditionally disadvantaged class or interference with a fundamental right otherwise protected by the Constitution, a statutory classification in the social welfare area will be disturbed by this Court only if it fails to "advance legitimate legislative goals in a rational fashion." Schweiker v. Wilson, 450 U.S. 221, 234 (1981). See Brown v. Board of Education, 347 U.S. 483 (1954); Califano v. Westcott, 443 U.S. 76 (1979); Jimenez v. Weinberger, 417 U.S. 608 (1974); Shapiro v. Thompson, 394 U.S. 618 (1969); U.S. Department of Agriculture v. Moreno, 413 U.S. 528 (1973).

The content of this "rational basis" standard has been a matter of continuing and often intense debate in the Court interpreting the equal protection guarantee

of the Fourteenth and Fifth Amendments. As the Court acknowledged last term, opinions of "[T]he most arrogant legal scholar would not claim that all of these cases applied a uniform or consistent test under the Equal Protection Clause." U.S. Railroad Retirement Board v. Fritz, 449 U.S. 166, 177 n. 10 (1980). On the one hand, the court has sometimes taken the approach initially suggested in Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61 (1911). Under this approach, a classification will be sustained "if any state of facts can reasonably be conceived that would sustain it." 220 U.S. at 78-79. See also Flemming v. Nestor, 363 U.S. 603 (1960); McGowan v. Maryland, 366 U.S. 420 (1961). On other occasions, the court has been less deferential, requiring that a classification bear a "fair and substantial

relationship to the object of the legislation" which enacted it. F.S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920). See also James v. Strange, 407 U.S. 128 (1972); McGinnis v. Royster, 410 U.S. 263 (1973).

The tension between these contrasting conceptions of the proper scope of judicial review under the Equal Protection Clause surfaced with striking clarity in the Court's very different treatment last term of two challenges to social welfare classifications. In U.S. Railroad Retirement Board v. Fritz, supra, the Court openly adopted the extremely deferential approach suggested by Lindsley, supra, holding that so long as there are "plausible reasons" for a classification and these reasons are advanced in a way that is not "patently arbitrary or irrational," the classification

must be sustained. Id. at 177. In Schweiker v. Wilson, supra, on the other hand, the Court set a significantly more exacting standard, one which demanded that a challenged classification "rationally advance a reasonable and identifiable governmental objective . . . [reflecting] . . . Congress' deliberate, considered choice." Id. at 235.

The contrast between these two approaches to "rational basis" review is rooted in the effect of two very different perceptions of the importance of the purposes articulated by a legislature for statutory classifications it enacts. In Fritz, the presence (or absence) of such articulated purposes was irrelevant: "where . . . it is, of course, 'constitutionally irrelevant whether this reasoning in fact underlay the legislature decision.'" Fritz,

supra, at 179 (citing Flemming v. Nestor, 363 U.S. at 612). In Wilson, however, the Court's ability to find a particular identifiable purpose and to trace the origins of that purpose to legislative deliberation rather than "inadvertence or ignorance" was central to the Court's validation of the welfare classification at issue. Schweiker v. Wilson, supra, at 236.

Amicus submits that the present case provides this Court with an appropriate opportunity to resolve the uncertainty which surrounds the role of articulated legislative purposes in equal protection analysis after Fritz and Wilson. Amicus further submits that the proposed method of resolution by Justice Powell in his dissenting opinion in Wilson (concurred in by Justices Brennan, Marshall and Stevens), 450 U.S. at 239, offers an approach to the

problem which advances the objective of legislative supremacy in law-making while insuring the protection of judicial review to persons arbitrarily harmed as a consequence of legislative inadvertence.

The present case invites a definitive explanation of the significance of articulated legislative purposes in constitutional challenges to social welfare classifications because the classification at issue in the case has been shown to serve no identifiable purpose whatever. As the district court held and as the Hogan class members have demonstrated in their brief to this Court (see Brief of Appellees, Argument I.A.), the discriminatory effects of Section 1903(b) of the Social Security Act, 42 U.S.C. § 1396b(f), which demands that medically needy aged and disabled people spend down to an income level below

that of Supplemental Security Income recipients (i.e., to four-thirds of the income standards applicable to recipients of Aid to Families With Dependent Children (AFDC)), were "never considered, let alone intended" by Congress. Hogan v. Harris, 501 F.Supp. 1129, 1137 (D.Mass. 1980). This requirement was instead "inadvertently" created, "the result of a legislative accident." Id.

For Justice Powell, a discriminatory classification enacted without "an identifiable purpose" presents a reviewing court "not so much with a legislative policy choice as its absence." Schweiker v. Wilson, supra, at 244. (Powell, J., dissenting) Under these circumstances, the classification must bear a "fair and substantial relation" to any post hoc hypothetical purposes asserted in

litigation by the government lawyers charged with defending it. Id., at 244-45, citing F.S. Royster Guano v. Virginia, supra, 253 U.S. at 415. Under this "fair and substantial relation" standard, it is not sufficient that the purpose claimed to be served by a statutory classification be one that is reasonably conceivable after the fact. The classification must instead be tied by a "logical link" to the purpose it purportedly serves. Id. at 246.

The chief merit of this approach is that it promotes conscious legislative policy choices. "When a legitimate purpose for a statute appears in the legislative history or is implicit in the statutory scheme itself, . . . [o]ur democratic system requires that [it] receive the most respectful deference." Id. at 244. It is only when such a purpose can be suggested

by nothing more than a litigator's "ingenuity" that such deference is suspended in favor of the "marginally more demanding scrutiny" entailed by the "fair and substantial" relation standard. Id. at 245.

A corollary virtue of the modest skepticism which Justice Powell suggests be reserved for classification supported only by "post-hoc hypothesis" id. is that the invalidation of such a classification presents little danger of improper interference with legislative prerogatives. For if, by assumption, Congress is unaware of the discriminatory consequences of a particular enactment, it can scarcely be said to have intended these consequences. The "fair and substantial relation" standard for evaluating inadvertent classifications against the constitutional

guarantee of equal protection of the laws thus assures that judicial review of social welfare measures will not be "toothless", Mathews v. Lucas, 427 U.S. 495, 510 (1976), without undermining the wishes of the people as expressed through their elected representatives. See Schweiker v. Wilson, supra, at 243, (Powell, J., dissenting). For these reasons, amicus respectfully urges the Court to employ this standard in its review of the Secretary's application of the four-thirds standard to the Hogan class.

II. THE APPLICATION OF THE "FOUR-THIRDS" AMENDMENT TO THE HOGAN CLASS DOES NOT BEAR A FAIR AND SUBSTANTIAL RELATION TO THE PURPOSE ASSERTED BY THE SECRETARY.

The first step in applying the fair and substantial relation standard in this case is to examine the history and structure of the four-thirds requirement for

any "indication of legislative purpose." Schweiker v. Wilson, supra, 450 U.S. at 244-45 (Powell, J., dissenting). Neither the legislative history nor the structure of the Medicaid statute generally or of the four-thirds requirement in particular, Section 1903 of the Social Security Act (42 U.S.C. § 1396b(f), reveals any purpose that might be served by forcing the Hogan class to spend down below Supplemental Security Income (SSI) (42 U.S.C. 1381 et seq.) levels before receiving Medicaid benefits. Brief of Appellees at parts I.A.1 and I.A.2. A requirement that a medically needy family spend down to four-thirds of the amount a similarly situated categorically eligible family would have received under a state's Aid to Families With Dependent Children (AFDC) program (42 U.S.C. 601 et seq.) may set a rational

standard of "medical need" when applied to AFDC recipients and those who would qualify for AFDC except for their income; medically needy "AFDC" families are required to spend down to an income level that is related to but always higher than that of their categorically needy counterparts. When, however, the "four-thirds of AFDC" standard is transposed to a different assistance program, SSI, which provides generally higher benefits than does AFDC, and categorically needy SSI recipients are exempted from the standard, the scheme's good sense disappears; the medically needy must now become poorer than the categorically needy in order to secure the same entitlement to Medicaid benefits. The risks anticipated by Justice Powell in Wilson, that "the importation of eligibility criteria from one statute to

another" will cause "irrational distinctions [to] be made between equally needy people" have indeed come to pass. Schweiker v. Wilson, 450 U.S. at 245 (Powell, J., dissenting).

It is not Congress, then, but the Secretary, through his attorneys, who offers reasons for nevertheless applying the four-thirds requirement to the Hogan class. Brief for Appellant at 18. The Secretary rests his argument chiefly on the proposition that requiring medically needy aged and disabled people to spend down to four-thirds of AFDC income standards encourages these people to purchase private medical insurance as a substitute for Medicaid coverage. In proposing this explanation, the Secretary does not dispute that the SSI income standards are subsistence income standards or that the SSI

program "was intended to provide a 'federal guaranteed minimum income level for aged, blind and disabled persons.'" Brief of Appellant at 23, quoting Senate Report No. 92-1230, 92nd Congress, 2nd session 1972 at 12. He does not deny that medically needy aged and disabled persons by definition have incomes which fall below this guaranteed level. The Secretary, therefore, does not and cannot contend that members of the Hogan class are less needy or less deserving than are categorically needy eligible SSI recipients. Brief of Appellant at 41. Nevertheless, the Secretary insists that to deny Medicaid benefits to the Hogan class by requiring them to satisfy the four-thirds requirement is a rational way to encourage the medically needy to purchase private health insurance.

Since there is no evidence that Congress ever sought to promote this goal, the Secretary's argument can be sustained under the "fair and substantial relation" standard only if there is a "logical link" between the four-thirds rule and the goal's attainment. Schweiker v. Wilson, supra, 450 U.S. at 246 (Powell, J., dissenting). The issue reduces, in short, to whether it is logical to reason that requiring the aged, blind and disabled to spend down below the SSI minimum income level in order to obtain Medicaid benefits will, in fact, encourage them to purchase private medical insurance.

The possibility of such a logical connection rests on the twin assumptions that insurance is available to the medically needy and that it would make economic good sense for them to buy it (i.e.,

that buying health insurance is a better gamble than is risking the spend down to the four-thirds of AFDC income level). If either assumption is incorrect, the four-thirds spend down requirement cannot be said to encourage members of the Hogan class and other similarly situated to purchase private medical insurance. While some forms of private insurance may theoretically be available to the medically needy aged and disabled, the brief submitted on behalf of the Hogan class demonstrates that coverage available under private health insurance policies is far less comprehensive than is Medicaid. Brief of Appellees at 50-51. Thus, regardless of whether a medically needy aged or disabled person is privately insured, he or she must still spend down to the four-thirds of AFDC level in order to secure

adequate coverage of his or her medical expenses. Since private insurance provides an inadequate alternative to Medicaid, and thus no alternative at all to spending down, application of the four-thirds rule to the medically needy aged and disabled can in no meaningful sense be said to encourage them to purchase private medical insurance coverage.

Even if adequate health insurance coverage were available to medically needy aged and disabled people, most of them could not meet the premium costs (see discussion at Brief of Appellee at 49). Moreover, the gross incomes (prior to medical expenses) of many members of the Hogan class are barely above the subsistence income level established by the SSI program. The cost of insurance premiums would surely reduce the incomes

of these class members to the point below the level necessary to provide for basic food, shelter and clothing. It just does not make sense to assume that a person would reduce his or her income below the subsistence level in order to provide a hedge against medical expenses he or she has not yet incurred. A medically needy aged or disabled person in this situation would thus be extremely unlikely to buy medical insurance, but would rather risk the spend down in order to provide for everyday needs.

Finally, the Secretary concurs that "the purpose of the Medicaid program is to provide medical assistance to the poor." (Brief for Appellant at 12.) Members of the Hogan class are at least as poor, and in some instances poorer, than the categorically needy who, as the Secretary

points out, "are among 'the most needy [people] in the country.'" (Brief of Appellant at 17, quoting H.R. Rep. No. 213, 89th Congress, 1st session 1965 at 66.) Application of the four-thirds rule imposed by section 1903(f) of the Social Security Act to medically needy aged and disabled people thus works directly against the fundamental objective of the Medicaid program. The classification is an oversight and does not withstand scrutiny under the "fair and substantial relation" standard. It should be invalidated.

SUMMARY CONCLUSION

For the foregoing reasons amicus Massachusetts Association of Older Americans respectfully urges this Court to affirm the decision of the district court.

Respectfully submitted,

BRUCE K. MILLER
Counsel for Amicus Curiae
Massachusetts Association
of Older Americans

DENNIS CARAHER
Of Counsel